DOCUMENT RESUME

ED 158 185 CG 012 762

AUTHOR	Dobrof, Rose; Litwak, Eugene
TITLE	Maintenance of Family Ties of Long-Term Care Patients: Theory and Guide to Practice.
SPONS AGENCY	National Inst. of Mental Health (DHEW), Rockville, Md.
PUB DATE	77
CONTRACT	278-75-0048
NOTE	126p.
AVAILABLE FROM	Superintendent of Documents, U.S. Government Printing Office, Washington, D.C., 20402 (Stock number 017-024-00537-8)
EDRS PRICE	MF-$0.83 HC-$7.35 Plus Postage.
DESCRIPTORS	Companions (Occupation); *Family Involvement; Family Relationship; *Family Role; Geriatrics; Institutional Environment; Institutional Personnel; *Institutional Role; Models; *Nursing Homes; *Older Adults; *Residential Care

ABSTRACT

This manual is based upon a study of 247 old people and their families and five long-term care facilities in New York City. The data indicate that what families do for their aged kin in institutions makes a difference to the older person, and that the ability of families to maintain contact with their institutionalized relative depends, in part, on the extent to which the institution encourages the presence and activities of families. The first part of this manual discusses how staff can work with aged residents, their families, and the family-less aged in long-term care facilities. There is a bibliography for this section and appendices with suggestions for application forms, interdepartmental memoranda, and a handbook for applicants and their families. The second part of the manual provides a theoretical formulation which can be used as the basis for the design and evaluation of long-term care facility policies and programs. This section includes an analysis of: (1) differences in structure and function between the long-term care facility and the family; (2) attributes of the institution and the family which create tension between them; (3) linkage mechanisms which institutions and families use which enable them to work together. (Author/RF)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

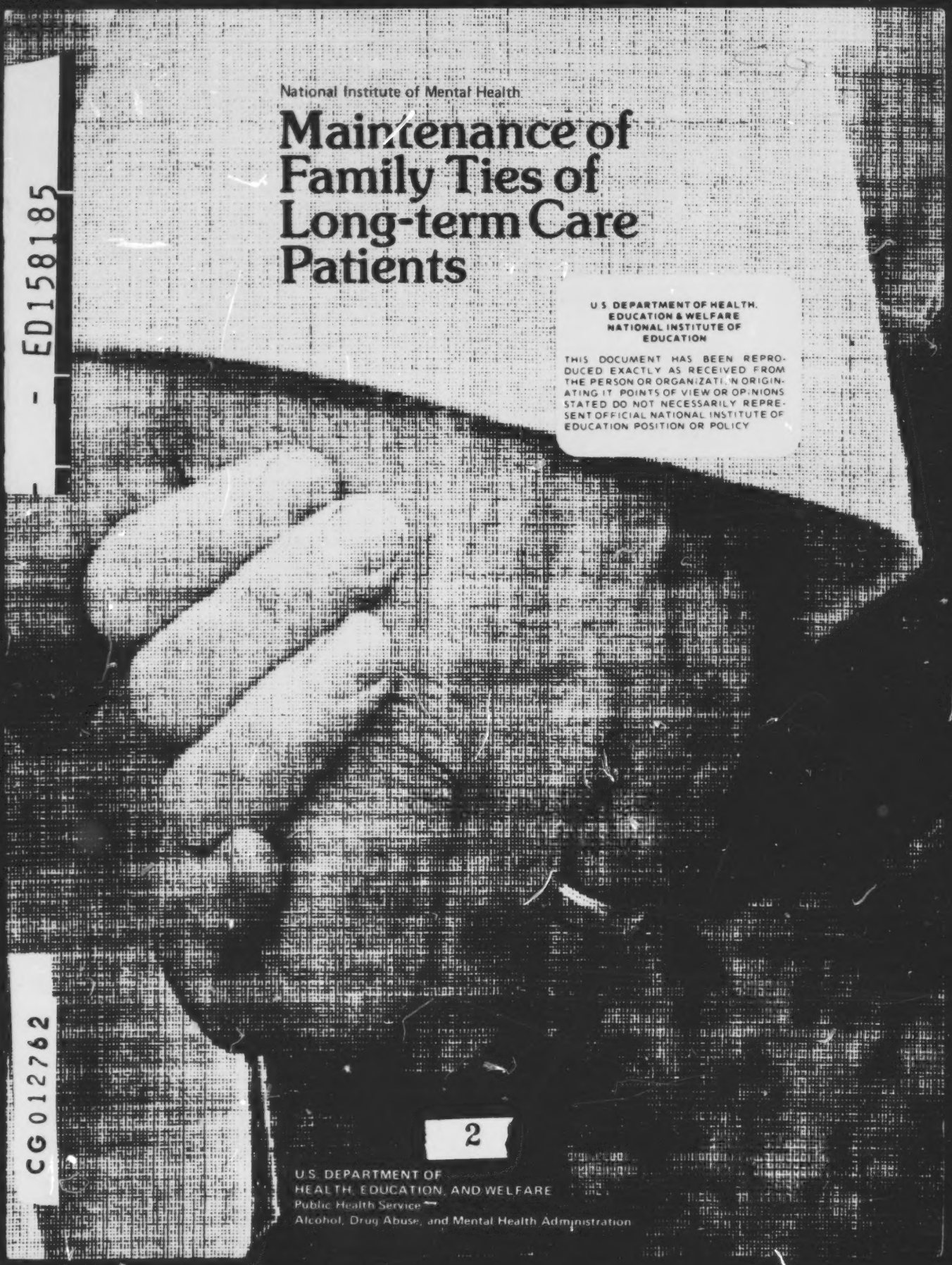
ED158185

National Institute of Mental Health

Maintenance of Family Ties of Long-term Care Patients

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
NATIONAL INSTITUTE OF EDUCATION

THIS DOCUMENT HAS BEEN REPRODUCED EXACTLY AS RECEIVED FROM THE PERSON OR ORGANIZATION ORIGINATING IT. POINTS OF VIEW OR OPINIONS STATED DO NOT NECESSARILY REPRESENT OFFICIAL NATIONAL INSTITUTE OF EDUCATION POSITION OR POLICY



CG 012762

2

U.S. DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
Public Health Service
Alcohol, Drug Abuse, and Mental Health Administration

MAINTENANCE OF FAMILY TIES OF LONG-TERM CARE PATIENTS: THEORY AND GUIDE TO PRACTICE

Rose Dobrof, D.S.W.
Associate Professor, School of Social Work
Executive Director, Brookdale Center on Aging
Hunter College of the City University of New York

and

Eugene Litwak, Ph.D.
Professor of Sociology and Social Work
Columbia University, New York City

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Public Health Service
Alcohol, Drug Abuse, and Mental Health Administration

National Institute of Mental Health
5600 Fishers Lane
Rockville, Maryland 20857

This publication was prepared under contract number 278-75-0048 (SM) and PSC No. 099-98-75 from the National Institute of Mental Health. The opinions expressed herein are the views of the author(s) and do not necessarily reflect the official position of the National Institute of Mental Health of the Alcohol, Drug Abuse, and Mental Health Administration, Public Health Service, U.S. Department of Health, Education, and Welfare.

DHEW Publication No. (ADM) 77-400
Printed 1977

For sale by the Superintendent of Documents, U.S. Government Printing Office
Washington, D.C. 20402

Stock No. 017-024-00537-6

Foreword

The development of this guide was supported by the National Institute of Mental Health because of our continuing concern for the mental health of aged residents of long-term care facilities. Along with the physical incapacities of persons entering such institutions is the loss of ties with relatives and friends, which adds to the aged residents' feelings of hopelessness in coping with the drastic environmental change. But the loss of relationships experienced by aged residents need not be as profound as it frequently is. Dr. Dobrof makes a strong case for the maintenance of familial ties of the aged residents, giving practical suggestions to the staff of long-term care facilities. Dr. Litwak, on whose concepts this guide is based, has written a clear description of his theory which can have broad implications for those who take seriously what he has to say. It is a clear-cut example of the application of theory to practice.

It is hoped that this publication will be of assistance to the staff of long-term care facilities and to all persons who are concerned about sustaining the mental health of aging persons admitted to institutions.

Gene D. Cohen, M.D.
Chief, Center for Studies of the
Mental Health of the Aging
Division of Special Mental Health Programs
National Institute of Mental Health

Contents

Foreword iii
Introduction vii

Part I – Guide to Practice
by Rose Dobrof, D.S.W.

Chapter 1. Making the Beginning: Families and Friends in the Application, Intake, and Admission Process 1
Chapter 2. The Work With Families in Process 12
Chapter 3. The Family-Less 25
Chapter 4. The Staff: Assignment, Communication, and Training 32
Chapter 5. Policies, Provisions, and Facilities: Obstacle Courses or Facilitators 37
Chapter 6. Family Programs 43
Chapter 7. Summary 45
Appendix I – Application and Intake Forms 49
Appendix II – Sample of Handbook for Residents 69
Bibliography for Part I 77

Part II – Theoretical Bases for Practice
by Eugene Litwak, Ph.D.

Chapter 8. The Role of Formal Organizations and Staff in Maximizing Technical Knowledge 80
Chapter 9. Economics of Large Scale and Primary Groups 85
Chapter 10. Alternative Theories of Relationship Between Formal Organizations and Primary Groups 86
Chapter 11. Theory of Staff and Kinship Linkages 97
Chapter 12. Some Illustrations of Family Types and Linkage Mechanism 103
Chapter 13. Summary and Conclusion 110
Appendix I – Other Forms of Primary Groups 112
References for Part II 115

Introduction

In 1961 I joined the social services staff of The Hebrew Home for the Aged at Riverdale and thereby entered the world of the aged in institutions, their families, and the staff. When the time came some years later for me to select a subject for my doctoral dissertation at the Columbia University School of Social Work, I knew that it was this world and the people in it that I wanted to study and write about.

I am deeply obligated to many people who helped in a variety of ways in the preparation of this manual, but the responsibility for its contents is, in the end, mine. My most profound debt is to the old people and their families who were the subjects of the study on which the manual is based. They answered questions that often recalled pain which they had experienced, and they talked thoughtfully about their family histories. In the process, they deepened both my understanding of and my respect for their humanity and their humanness.

The loci of the study were five long-term care facilities in New York City. Having served on the staff of one of these institutions, I knew the imposition on staff time and energy which a study like this represented. It is not possible to acknowledge by name all of the staff who were so generous with their help. It must suffice to say thank you to Mr. Jacob Reingold, Executive Vice-President, The Hebrew Home for the Aged at Riverdale; Mr. Larry Larsen, Executive Vice-President, Isabella Geriatric Center; Mrs. Rose Baratzer, Administrator, Kingsbridge Heights Nursing Home; Sister Eilharda, Executive Director, Frances Schervier Home and Hospital; and Mrs. Nseri Afzal, Director of Social Services, Bird S. Coler Hospital.

The environment of the Hunter College School of Social Work and the Brookdale Center on Aging is hospitable to serious work by faculty and staff, and in large measure reflects the leadership provided by Jacqueline Wexler, President of the College, and Harold Lewis, Dean of the School of Social Work. They know how important their encouragement was to me, as was that of Harry R. Moody, Executive Secretary of the Brookdale Center, and Mrs. Hannah Rodell, Administrative Assistant.

My intellectual debt to Eugene Litwak of the Columbia University Department of Sociology and School of Social Work will, I am certain, be visible to the reader. And, finally, my thanks to Thomas Anderson, Ph.D., and Marie Blank, M.S.W., of the Center on Aging of NIMH. To say only that Mrs. Blank served as Project Officer is not to convey in any real sense her role in making this manual possible. Without her, it would not have been.

The dissertation was a study of 247 old people and their families and five long-term care facilities in New York City. I tried in the study to find out what kinds of things the aged residents and patients still wanted their families to do for them; what responsibilities families continued to feel were theirs, even though their aged relations lived in the institution; and finally what things the institution and its staff could do to help families carry their responsibilities.

As we analyzed the responses to our questions of the residents and patients and their relatives, as we looked at the policies and programs of the five institutions and compared them with each other, several things became clear. First, what families did for their aged relatives in the institutions—their visits, phone calls, special food treats and other gifts—made a difference in the lives of the old people. And second, the ability of the families to do these things depended in part on the degree to which the institution and its staff made the families feel welcome in the institution and encouraged their efforts on behalf of their aged relatives.

These two points may seem at first glance to be obvious to anyone who has worked

in homes for the aged and skilled nursing homes and other long-term care facilities. We have all known old people for whom the fact of being in the institution signified abandonment by their families. We have all worked with angry and sad patients and residents who feel that their families don't visit often enough, don't do enough for them. We ourselves have sometimes shared these feelings of anger and resentment at families: Why didn't Mrs. Smith's children keep her at home? She has so little time left. Or why don't the children visit oftener or stay longer when they come when they know how much it means to their mother?

Since we all know that it's important that the relationships between the old people in the institution and their families be maintained, and we do everything we can to make families feel welcome, why is a manual on this subject necessary? There are, first, our own feelings which must be acknowledged.

Elaine Brody writes about the "myth . . . of the alienation of old people from their families"[1]—the widely and deeply held belief that lonely old people live in the community, separated geographically and psychologically from their children—that entry into the institution is made necessary not because the declining health status of the old person makes the protective and supportive environment of the institution the arrangement of choice, but rather as a poor substitute for a loving, caring three-generation household.

The myth is a persistent one; it is in newspaper and magazine articles about the aged.[2] It underlies the speeches of public officials who talk about "healthy old people being 'warehoused' " in long-term care facilities. It appears in professional literature. It often adds an unnecessary dimension of pain for families and old people alike who know that entry into the institution is the right decision, yet fear they will be criticized by other relatives and friends for having made the decision.

And we who staff long-term care facilities are not exempt from the influence of this myth: When, as in the case of Mrs. Smith, staff members experience her feelings of hurt, anger, and resentment at her children, our ability to help is diminished. And our sense of pride in our own work is corrupted. Who can feel their work is socially useful if they, and others, see themselves as the keepers of the warehouses for the unwanted of society? Who wants to be part of institutions which permit, and even encourage, children to run away from their responsibility to parents?

The first purpose of the manual is to offer a systematic way of translating into action the idea of institution and families and friends as partners. If a partnership exists, what are the responsibilities of each partner? Who does what? What should the family be able to expect from the institution? And what should staff be able to call on the family for?

Are there policies and procedures of the long-term care facilities which have become obstacles for families and old people? If families are our partners, do we unintentionally deliver other kinds of messages about the relationship? Is there more we could be doing to nurture the relationship between the old person and her family and friends outside the institution?

How are staff assignments for work with families and friends made? And what kind of information about the family and friendship relationships of the aged residents and patients does staff need in order to do their job? If the institution defines families and friends as partners, what kind of inservice staff training is required?

Finally, what of the socially isolated old person? The sole survivor of a family group? The loner estranged from family? The old person whose family is separated from her by

---

[1] Brody, Elaine and contributors. *A Social Work Guide for Long-Term Care Facilities,* National Institute of Mental Health. DHEW Publication No. (ADM) 75-177. Washington, D.C.: Superintendent of Documents, U.S. Government Printing Office, 1975. p. 73.

[2] The feature article on the aged in the United States in *Time Magazine,* August 3, 1970, was entitled "Growing Old in America: the Unwanted Generation." The title and much of the content of the article seemed based on the myth of abandonment and alienation.

geographic distance? Can surrogate relatives be provided by the long-term care facilities? How?

As the title of the manual suggests, it is both theoretical and practical in its approach. The first part of this manual discusses how to work with our aged residents and patients, their families, and the family-less or isolated aged in long-term care facilities.

There is a bibliography for this section of the manual and appendices with suggestions for application forms, interdepartmental memoranda, and a handbook for applicants and their families.

I have tried to write these chapters so that the manual may be useful to staff, regardless of the size, auspice, or geographic location of the facility. I have tried also to take into account the variations among institutions in the number of staff, their credentials and staffing patterns. I write as a social worker, mindful that historically the task definition of my profession in settings like long-term care facilities have included primary responsibility for work with families. I believe that this work *should* be included in the job description of the social worker in these facilities, that work with families is a social service which long-term care facilities *should* provide.

Ideally, the responsibility for work with families is assigned to the social service staff and that staff is held accountable for performance of this work. But the partnership between institution and families is a real working relationship only if the staff approaches their part of the work as a team. Hence, throughout the manual, there is emphasis on dissemination of information to all staff, on staff training, and on other essentials to a team approach.

Moreover, I am mindful of the fact that other professions, nursing for example, include attention to the psychosocial components of the long-term care in their task definition and that work with families is part of that definition. I write from the vantage point of my own profession, but this should not be interpreted as a belief that work with families is "a turf" to be laid claim to by my profession. The task is too important; the work, too demanding: A team approach, with all staff members working in cooperation with each other, is not a dream, but a necessity.

I have used case examples as the way of organizing the content and illustrating the principles, a useful way of capturing both the variety of situations faced and the commonalities among these situations which permit us then to make generalizations which can be used in practice. All of the cases come from my study; I have, of course, made some changes to protect the identity of the people.

There are frequent references to *A Social Work Guide for Long-Term Care Facilities* by Elaine Brody and her associates which was published in 1974 by the National Institute of Mental Health. Mrs. Marie Blank of NIMH served as consultant in preparation of both the Brody *Guide* and this manual which are issued under the imprimatur of the Institute. In a sense, my work builds on the strong foundation provided by Mrs. Brody and her collaborators. The attention in Part I is to one aspect of our work in long-term care facilities—the maintenance of relationships between the institutionalized aged and their families.

The second part of the manual provides a theoretical formulation which can be used as the basis on which long-term care facility policies and programs can be designed and evaluated. This theoretical formulation was written by Eugene Litwak, Ph.D., Professor of Sociology and Social Work at Columbia University.

It is Litwak's Shared Function theory which provided the framework for the study on which this manual is based and the explication of it here will, I believe, be useful to administrators and staff members in long-term care facilities. I have said that in the analysis of the data we collected for the dissertation there were two themes which seemed important for consideration: (1) what families did for their aged kin in the institutions made a difference to the old person; and (2) the ability of families to maintain contact with their institutionalized relative depended, in part, on the extent to which the institution encouraged the presence and activities of families.

Litwak's chapters have a systematic explication of these findings. Here, from the vantage point of the sociologist there is analysis of the differences in structure and function between the formal organization—the long-term care facility—and the primary group —the family. This analysis, I think, deepens our understanding of the importance of the maintenance of family relationships, of the limits of even the best facility, of the importance of the partnership between facility and family.

There is also a discussion of the attributes of the institution and the family which create the tension between them which all of us have experienced; and there is an analysis of "the middle point in the social distance between them." Achievement of this relationship permits coordination of the efforts of the family and the facility in a fashion which minimizes potential for clashes and disagreements. Litwak analyzes the "Linkage Mechanisms" which institutions and families use in order to achieve the distance which enables them to work together.

This analysis is particularly valuable for the staff concerned about problems of involvement of kin. It provides a framework for the earlier chapters on policies and programs. In these earlier chapters and also in the appendices I emphasize the institution's getting to know, and working with, *all* of the family members—not just the key relative or the responsible family member. Litwak discusses the difference between extended and nuclear families, particularly how the differences affect the linkage mechanisms that institutions use to facilitate the family's appropriate involvement in the life of an aged relative in the institution. Litwak talks also about "Alternatives to Kin Groups"—the theoretical argument for the use of volunteers as "friendly visitors" or surrogate families as illustrated in several of the cases presented in the earlier chapters.

The manual, therefore, addresses both the why and the how of maintenance of familial relationships. Our work, if it is to be truly helpful, must always rest on a sound theoretical foundation: The *how* of the first seven chapters of this manual is informed by the *why* of the final chapters.

Rose Dobrof, D.S.W.

PART I – Guide to Practice
by Rose Dobrof, D.S.W.

Chapter 1. Making the Beginning: Families and Friends in the Application, Intake, and Admission Process

Many people have written about the admissions process to long-term care facilities, and in the bibliography for this chapter there is a selected list of these writings. There is a recurrent theme which runs as a thread of commonality in these writings about the admissions process, a useful beginning for this discussion.

The entry of the old person into a long-term care facility is never an easy time either for the individual or for the family and friends. Notice the word *never*: No matter how close and loving the family and friendship relationships are; no matter if the decision to seek entry into the institution has been made by the old person and the people important to her[1] after careful thought and exploration of all possible alternative arrangements; even if the old person and her family have been able to visit different facilities and choose the one which she and her family and her doctor and her neighbors and friends think is the "right" one for her – even if all of these conditions and more are met, the statement still stands. From the moment that the possibility of entering a long-term care facility is first entertained by the old person and the people around her, she and they are experiencing one of life's most serious and painful crises.

If we look at why this is so, we can begin looking at the *what* and the *how* of the staff-family partnership. Let's take a paragraph from Blenkner, which includes in it some conclusions reached by Ethel Shanas in her 1962 study of the health status and needs of older people. Let us compare Blenkner's and Shanas' conclusions with some from my study, and then let's put this discussion in Litwak's theoretical framework and finally talk about how the relationship between the institution staff, the old person, and her family and friends should begin.

Blenkner writes:

> The thought of entering a home for the aged or a nursing home is extremely unpopular among the elderly. Among the older applicants interviewed in the previously mentioned New York study, only seven per cent selected "home for the aged" as their preferred dwelling place, despite the fact that many had applied for just that purpose, and none preferred living in a nursing or boarding home. Among a representative sample of nonapplicant New Yorkers 60 and over interviewed in the same study, only one per cent selected "home for the aged" and, like the applicants, none selected nursing or boarding home. Shanas found three per cent of her 65 years and over sample preferring such living arrangements. Her summarization of why older people feel the way they do about nursing homes and homes for the aged should be read and re-read by every social worker who counsels adult children regarding care of their aged parents. Below are some excerpts from it:
>
> Almost all older people view the move to a nursing home with fear and hostility. . . . All old people—without exception—believe that the move to an institution is a prelude to death. . . . (The old person) sees the move to an institution as a decisive change in living arrangements, the last change he will experience before he dies. . . . Finally, no matter what the extenuating circumstances, the older person who has children interprets the move to an institution as rejection by his children.[2]

[1] Given the fact that women constitute the majority of older residents and patients in long-term care facilities, the feminine pronouns will be used throughout this manual, rather than the more cumbersome him/her, his/hers.

[2] Blenkner, Margaret. Social work and family relationships in later life with some thoughts on filial maturity. In: Shanas, Ethel, and Streib, Gordon, eds, *Social Structure and the Family: Generational Relations.* Englewood Cliffs, N.J.: Prentice-Hall, 1965.

It would be folly to argue with Blenkner's and Shanas' conclusion that old people do not consider entry into a long-term care facility as a *preferred* living arrangement. Our colleagues in community agencies serving the aged tell us also of the struggle their clients make to live independently and maintain themselves in their own homes. In my study, the interview with the aged in the institution included the question: "Did you ever think you might come to a place like this to live?," and most of the people answered the question in the negative. They were, I think, not unlike the people in the Shanas study: If they had been interviewed *x* number of years prior to their admission to the long-term care facility, most would not have selected a home for the aged as their preferred living arrangement and probably would have viewed the possibility with fear and with the knowledge that it would constitute, in Shanas' words, "a decisive change . . . the last change. . . ."

But what they said about why they had not thought in their earlier years about the possibility of a home for the aged and how they came to the decision led me to rather different conclusions from Blenkner's and Shanas'. These conclusions are, I think, important in considering how to begin work with old people and their families.

The Paths to the Institution: The Cases of Miss Anderson, Mrs. Barth, Miss Farrell, Mrs. Kaye, and Mrs. Porter

Unlike Blenkner, Shanas, and many other professionals in the field, I did not in my experience or in my study find validation for the generalization " . . . no matter what the extenuating circumstances, the older person who has children interprets the move to the institution as rejection by his children."[3] That many older people do interpret the move in this fashion cannot be gainsayed; and Mrs. Barth, Mrs. Porter, Mrs. Long, and Mrs. Gross, whom you will soon get to know, and Mrs. Smith to whom I referred briefly in the introduction, are examples of such people. Mrs. Kaye, on the other hand, is not. There were many Mrs. Kaye's in my study, and in my work experience I have known many people like her. Some, in fact, initiated the application to the long-term care facility themselves, sometimes against the wishes of their children.

I concluded that many older people do not sanction multigeneration families living under one roof any more than their children do. As you will see in Mrs. Barth's case, many, like her, have observed these arrangements and decided that "it doesn't work." Others reported that they themselves in their middle years had cared for aged parents in their own homes and had vowed then that, if the time came when they could no longer maintain themselves in their own homes, they would choose to enter a home for the aged.

Interestingly, many older people and their children alike in the separate interviews expressed the hope that people like myself would write about this subject so that others would understand that the entry of the old person into the institution does not reflect rejection of them by their family, nor are they abandoned after institutionalization. One son-in-law who came with his wife every Sunday afternoon said:

> I often feel uncomfortable when people ask me where Claire's mother is and I tell them she's in the home. They don't seem to understand or believe me when I say that this was her choice—that we visit her all the time—that she spends many weekends with us—and that she's happier and in better shape than she's been since my father-in-law died 10 years ago.
>
> I wish people would understand that a good home like this can be the best arrangement for someone like Mom. She needs the care and company and things to do—and she knew it and we did too.

In place of the generalization made by Shanas, I would say that sometimes the older person who has children interprets the move to the institution as rejection by his children. Sometimes, in fact, the interpretation is correct; sometimes, however, the decision reflects the family's attempt to secure the best possible care and living situation for an aged parent.

Because entry into the institution is a time of crisis, as the old person and her family face her declining health status, all of the mixed feelings which characterize close relationships among human beings may surface. Often the older person may *initially* feel the experience as rejection and only after she is settled in and *sees* that her family is not abandoning her will those feelings of rejection become dissipated.

---

[3] *Ibid.*

The circumstances of the entry into the institution, the path the older person and her family took, the process of decisionmaking must all be understood by the staff. Then the staff and the old person and family can make an assessment of the meaning of this experience and can begin the process of helping both the parent and the children.

To illustrate this process let me quote from several of the interviews in my study. The subject in one interview was a 86-year-old woman, Miss Anderson, living in the skilled nursing section of a large voluntary institution. She was single and had been a successful career woman until her retirement in her late 60's. She had a large family of sisters, brothers, cousins, and a wide circle of friends. Her retirement years, as she and her niece whom I interviewed described them, had been good years; she had savings, a generous retirement income, and a busy life, including frequent shared activities with family and friends. When she was 83, she broke her hip, and, after months in an acute treatment hospital and then in the hospital's rehabilitation center, it became clear that the hip was not going to mend and that she was, in her words, "a prisoner in a wheelchair." When I interviewed her, she had been in the home for almost 2 years. Her room was full of plants, pictures of her family; there were greeting cards on her dresser and windowsill, and she had a private telephone on her bedside table. The aide had just brought her back from a meeting of the home newspaper staff and was transferring her from the wheelchair to her bed.

The question about whether she had ever thought about living in a home for the aged came late in the interview. By that time, I already had the picture of an active, independent woman who still maintained frequent contact with her family and friends through their visits to her, phone calls, letters, and gifts and who at the same time had made a new life for herself in the home. When I asked her the question, her first answer was, "Good God, no. Who in their right mind would ever think of this?" And with that she slapped the cast which encased her from hip to toe. Then she went on:

> To tell you the truth, I never thought I'd live to be this old. My father died in his 50's and my mother when she was 67. I can't remember any really old people in my family when I was growing up. And you know, when you're young you never think that you're going to be old.
>
> Then as I got older – I guess when I was in my 50's maybe, I thought "Well, I'll work until I die." Then I didn't. I retired, and I was healthy and I had enough money and my family and friends and my apartment. So I thought "This is the way it will be until I die." And those were good years. [And then she told me about her travels and the plays she had seen and her regular bridge game and her church work.]
>
> And then this [and again she slapped the cast]. At first I couldn't believe that I wouldn't be able to walk again, but the time came when I had to accept that this was the way it was going to be.
>
> We talked about my going back to the apartment with someone to help me. My brother and sister-in-law have a big house and we're very close and they offered me a home. My niece did too, and they all meant it – I could have lived with them.
>
> But look at what I need – help to do every little thing or staying in bed all the time. We could have hired someone – I still have some money left, and all the family offered to pitch in and help with the expenses.
>
> But I knew it wouldn't work. You can do that if it is a temporary situation and you know you're going to get well. But this is day in and day out—and my brother and sister-in-law are in their 80's now, too. And my niece works.
>
> What would happen if the person we hired didn't show up one day or quit? Then I really would have been stuck.
>
> Here you know that there's always someone to help you—and I don't feel as if I'm imposing on anyone. . . .
>
> No, I never thought of a place like this—I don't even think I knew there were such places. But I never thought I'd be 86 either and surely never imagined that I'd end up in a wheelchair.

First, Miss Anderson had never thought she would end her days in a home for the aged, because, like most young people, it was almost impossible for her—at age 20 or 30 or 40—to imagine herself as an old person. And there was an additional factor in Miss Anderson's life which is also not uncommon among the present generation of older people. She was born in 1886; she was a teenager at the turn of the century when there were only around 4 million Americans over the age of 65. There may have been old people in her family but none close

enough and important enough for her to remember. Her parents, particularly her father, died at relatively young ages by today's standards.

It was understandable that in her young and mature adulthood, consciously or unconsciously, she rather assumed that she, like them, would not live to be old. When she did live past the ages at which they died, she was still healthy, independent, active, never having witnessed in her family the injuries, illnesses, and frailties of the very old. It was not unnatural for her to assume (and hope) that she would be spared this experience. Is there one among us who does not hold the same hope—that we will live out our lives in good health and die quickly and painlessly in the fullness of our time?

Second, Miss Anderson knew nothing about homes for the aged or nursing homes. In contrast to Mrs. Barth, the subject of the next interview, not only had no one in her family or close circle of friends been in such a facility, but the church and other charitable work Miss Anderson and her family and friends had done had never included support of or volunteer service in a home for the aged. If Miss Anderson had been part of the Shanas study at any earlier point in her life, she would have had only a vague picture of what a home for the aged was.

Third, after Miss Anderson became incapacitated, she knew that she was now dependent on others to help her manage each hour of each day. She knew that this was not a responsibility which her family could or should carry. She said if it were temporary, if it were for a matter of days or weeks, or, in her case, because her family was a large one with substantial financial resources, even several months, the alternatives of returning to her own apartment or going to the home of her brother or her niece would have been real.

Litwak's chapters in this manual distinguish between *uniform* and *nonuniform* tasks. Uniform tasks are those which are repetitive, require experts to handle them, and amass resources—personnel, facilities, equipment. It usually takes an organization like a long-term care facility to handle such tasks: The family, by itself, does not have enough members, nor do they have the expertise to handle uniform tasks.

In Litwak's terms, what had been a nonuniform situation, and therefore within the province of the family, had now become a uniform situation, one better handled by the institution. The duration of the situation for the rest of Miss Anderson's life—the fact that her incapacity meant that she needed help getting in and out of bed, toileting, bathing, and dressing, getting from one place to the other—made the situation a uniform one.

Miss Anderson did not talk in the language of the sociologist, but, when she asked, "What would happen if the person we had didn't show up or quit?," she was saying that her need for care was now no longer idiosyncratic—occurring infrequently and/or for a time-limited period—and, therefore, the institution, because of its greater resources, could guarantee the continuity of care which she now needed. Her family *could* do it, but, when she talked about the ages of her brother and sister-in-law and the fact that her niece worked, she was recognizing that the family's assumption of this responsibility would be at the cost of its ability to perform other essential family functions.

Family members would know how to do or could easily be trained by a nurse or a home health care worker to personally assist her. But maintenance of her functional health at the maximum level possible required expertise—nursing supervision and care, physical therapy prescribed and monitored by a physiatrist, for example. The provision of the care Miss Anderson needed had become a uniform function by virtue of duration of time, frequency, and the need for expertise.

In essence, Miss Anderson would not have *chosen* a home for the aged as her preferred living arrangement, for she would not have *chosen* to be incapacitated. She came in crisis, and, I am sure, in fear. But the decision was hers and her family's; the institution was for her not the last resort, but the arrangement of choice. I'll return to Miss Anderson later when the subject is the ongoing relationship between the institution and the family and the complementarity of their responsibilities.

Now, another interview.

The interview with Mrs. Barth was punctuated by sighs and tears, and it was unnecessary to ask the question whether Mrs. Barth had ever thought she would live in a home for the aged. She had always known about such places; there were other members of her family, both her own and the generation before her, who had spent their last years in homes for the aged. She, like Miss Anderson, was in a very good one, and, as with Miss Anderson, it was obvious the minute you walked into her room that she was a mem-

ber of a family who maintained ties to her. Her dresser was covered with pictures – some of them old, showing Mrs. Barth as a bride, a young mother of two small boys, and a proud mother in the wedding pictures of her sons. Some were recent – Mrs. Barth as the grandmother and her sons as the fathers of brides and grooms, Mrs. Barth in the center of a four-generation family picture which she said had been taken at the celebration of her 80th birthday just 2 years before our interview and 3 years after her entry into the home.

Like Miss Anderson, Mrs. Barth had her own phone, television, radio, and also a small refrigerator which had been one of her 80th birthday gifts. When we counted the number of relatives who had visited Mrs. Barth within the last 6 months, it totaled 33, and she had visitors at least twice a week. (The social services record included the notation that Mrs. Barth's roommate had complained on several occasions because Mrs. Barth had so many visitors – particularly on Sundays – that there was no place in the room for her roommate's relatives to sit.)

But she had never expected that she would "be put in a home," and in the 5 years she had been there she had remained a loner – busy, because she had always kept busy, but in solitary activities – knitting, crocheting, watching TV, walking about the grounds of the home. There was no one in the home, even her roommate, whom she considered a friend; she felt the people and the staff were nice, but, waving to the pictures on the dresser, "They're the only people who count."

What had happened that she came to the home? Mr. and Mrs. Barth had lived in the same apartment for 30 years or so. Mrs. Barth had never worked outside her home:

> I was a wife and a mother. What else did I have to be? The boys left, set up their own homes; Mr. Barth retired; they lived quietly. [Both had heart trouble; Mr. Barth's eyesight was failing; and both had rheumatism, but they managed.] And then one night [it was as if it were last week, instead of almost 6 years ago the way Mrs. Barth talked], Mr. Barth had a heart attack and was gone before the doctor could even get there.

She went to Richard's house after the funeral and for the mourning period. She spent maybe 6 weeks there and then went to her other son's house. "They were worried I shouldn't be alone in the apartment." She didn't remember just how long she stayed at her younger son's – a few weeks, a month – and then one Sunday afternoon, her sons took her for a ride.

The ride was to show her the home. A new building had just been opened and the rooms were beautiful and there were plenty of people around and things to do so she wouldn't be alone and think about or continue to mourn Mr. Barth all the time. And if she got sick in the middle of the night, there would be someone there to take care of her. Her sons had already made an application for her and she was scheduled for her medical examination and social service interview in a couple of weeks.

Mrs. Barth wept as she told of that afternoon and the weeks that followed. She had pleaded with "the boys" to let her return to her own apartment – just a few more weeks at her son's house to give her a chance to adjust to the father's death, and then she'd feel well enough to go home and manage for herself. The cleaning lady would come, and maybe she could get a student to live with her so she wouldn't be alone at night.

But "the boys" insisted: They loved her and they would worry about her constantly if she were alone in the apartment. Her heart was bad; her rheumatism was making it hard for her to get around. She wouldn't eat right with no one else there. A student wouldn't work; they knew other families who had tried.

Finally, Mrs. Barth said, she gave in:

> What could I do? They thought they were doing right. But I could have stayed in my apartment – I know I could. [Had she and the family thought about her living at one of the son's homes—or rotating between them?] No, I couldn't have done that. We never talked about that. They live so far out. [Both sons live in suburban communities.] They have their own lives; I'd just be in the way.

I interviewed Richard who visits his mother regularly twice a week, once during the week in the evening on his way home from work, and on Sunday when his wife and children and grandchildren often come with him. His brother Michael and his family come then, too, and they often bring Mrs. Barth's sister. Her nephews and nieces come every month or so.

Richard's memory of Mrs. Barth's admission was unexpectedly similar to Mrs. Barth's presentation. They had rushed her to decision, he said; they had, in fact, made the decision and confronted her with it as an accomplished fact.

What Mrs. Barth had not known was that her sons and their wives and children had been talking about the home for both of their parents for at least a year before their father's death. They had seen both Mr. and Mrs. Barth's health failing; they had worried about Mr. Barth's increasing dependence on Mrs. Barth for help and his decreasing ability to perform the tasks that had been his. They feared that Mrs. Barth's own health was in jeopardy, and, except for the cleaning woman once a week, they had been unable to persuade her to allow others – except for her sons – to help her.

After their father's death, they knew she could not live alone but thought also that, although she talked about getting someone to live with her, she wouldn't really accept this arrangement. In the months just before he died, there had been an increasing number of late night and early morning calls to them from their mother who was worried about their father and asked them to call the doctor and come themselves. They foresaw, if she returned to the apartment, such a pattern, and neither son could meet these demands on a regular basis.

They knew Mrs. Barth had had little life outside her family; she had never had close friends, and they didn't expect her to be different in the home. But they knew there would be *things* to keep her busy and *people* to take care of her, and "we could rest easy." In the end, Richard knew that Mrs. Barth had given in because he and Michael had asked her to do so for them.

The possibility of her living permanently with either of them had been discussed briefly by the brothers and their wives, but had not been considered seriously. Both wives worked; the children were either married or in school; the houses were empty all day; and neither lived in a neighborhood where there were old people around or shopping areas within walking distance. They knew also that Mr. and Mrs. Barth had often said that parents should not move in with their children; they had watched some of their contemporaries do so and had always said, "It doesn't work."

Richard knew his mother wasn't happy in the home, but he didn't think she would have been happier any other place.

> It's just sad for a woman like my mother; when we left home and then when Dad died, her main reasons for living were gone.
>
> Maybe it would have been better if we had given her more time after Dad died. Maybe we should have let her go back to the apartment for a while. I know she thinks that. But the truth is she was scared to go back, and she never mentioned it until after we brought her here that first Sunday.
>
> I wish it could have been different, and Miss Dunn [his mother's social worker at the time of her admission] kept telling us that maybe we should wait. She [the mother] also talked to us about how guilty we must all feel. I think she thought we *should* feel guilty, but the truth is mostly we felt sad. But we did think – and we still do – that we did right.

The difference between the mother and the son's presentations was in their estimate of her health status. She thought she could manage; they didn't. And she had no memory of the frequency of her calls for help from them. Unlike Miss Anderson, the decision was not Mrs. Barth's. Although both entered at a time of crisis, Miss Anderson's incapacity made her need for the institution less ambiguous, less open for differential estimates. They were similar in what they said about not wanting to live with their families.

The staff of the home – and the reader – may wonder if Mrs. Barth really meant what she said, may ask, if the children had offered her a permanent home, would she have said yes.

I do not think it's useful to speculate about whether that arrangement would have worked out well. The important thing is that Mrs. Barth's ability to manage by herself was clearly declining; the frequency of the calls for help was the signal that what had been infrequent events were now becoming frequent, and the shift from nonuniform to uniform, while gradual, was occurring.

A third person interviewed, Miss Farrell, was a tiny, still beautiful woman, age 72, when I met her in the municipal long-term care facility where she had lived for 4 years. She had been a pianist, playing in movie houses early in her career and then as an accompanist to church choirs and other community musical groups. She was an only child and had lived all her life in her parents' home. Her mother died first when Miss Farrell was in her 50's, and her father and she maintained their home until his death when she was in her early 60's. Miss Farrell lived alone then until she was 68. Her memory was clear for past events except for the details of her entry

into the long-term care facility. And her observations about staff, other patients, and life in the institution were acute. She knew everyone on her unit by name; she knew the staff and what she called "the pecking order." She wasn't active – except as a pianist – and she called no one her friend.

She had a severe case of emphysema and congestive heart failure, and she accounted for her role as observer rather than participant in the community of her unit partly because of health and partly because she saw herself as having little in common with the other patients. She was stable middle class; her family had settled in upstate New York in the early 1800's; she was cultured and sophisticated. She had never needed friends; her family and work were enough. She was polite in her relationships in the institution as she had been with her colleagues and neighbors in the years before she entered the facility. But she had always been standoffish, she said, and she saw no reason to change now.

A cousin living in the metropolitan New York area had been listed as her responsible relative. This cousin and her family and another one, living in the Midwest, were the only relatives she had. Except for yearly Christmas cards, there had been no contact with them since the death of her father.

"But we were always like that; it was just the three of us."

She had never thought about coming to a place like this – even after her father's death and the increasing seriousness of her health problems. Then one day while shopping she had heart failure and was rushed by ambulance to a municipal acute treatment hospital. She didn't know how long she was there; she remembered vaguely the doctor, the nurse, a social worker, and the minister of her church talking with her about her need for constant medical and nursing care. She doubted that her cousins had been consulted; she remembered agreeing with her minister that a long-term care hospital was the best place for her, and she remembered the ambulance ride.

The Protestant chaplain of the hospital was her only visitor and she looked forward to the weekly services and his monthly pastoral call on her. She didn't need anything else; she took care of her own room, played the piano every day, read and listened to music on her radio. Mostly she took care of herself; she had placed herself on a daily regimen of rest periods and she went to bed early every night "to save my strength." She hadn't been out of the institution since she came in; her health, she said, wouldn't permit such excursions.

She saw no point in my interviewing her cousin; she was a *relative*, not *family*, but she didn't object. When I tried to reach the cousin, I found that the phone and address listing in the institution records was incorrect, and there was no listing in the phone book or the telephone company records.

Staff confirmed every detail of Miss Farrell's presentation of herself. According to the nursing supervisor on the unit,

> She just isn't people oriented. She's always polite, never gives us or other patients any trouble. She seems completely content and entirely self-involved. She needs us because she's sick, but she doesn't seem to need anyone emotionally. She'd miss the minister if he didn't come, but it wouldn't be a real loss to her, and if he were replaced by another chaplain, I think she'd shift easily to him.

Now another interview.

Mrs. Kaye was the mother of four sons and one daughter – all married, in their late 40's and early 50's when she came into the home, age 76, and widowed 1 year before admission. When she was in her 50's, she began to have difficulty walking and the diagnosis was a progressive degenerative condition.

Despite her handicap, she and her husband managed together. Her daughter and one son lived nearby and took the Kaye's to their clinic appointments, shopping, and for frequent visits to their homes and the home of a second son who lived in a suburban community. Her other two sons lived in the Midwest; both phoned and wrote their parents frequently and visited them several times a year. One, the most affluent of her children, contributed regularly to their support.

During the last years of Mr. Kaye's life, Mrs. Kaye became wheelchair-bound. The family employed an aide who came in daily to help Mrs. Kaye get out of bed, toilet, and dress. Before the aide left late in the afternoon, she got Mrs. Kaye settled back in bed for the night, and Mr. Kaye gave her the bedpan when she needed it during the night. The two children and the son's wife who lived in the neighborhood rotated the duty, so that one was there each day, and the Kaye's had close friends in the building who also helped out.

243-962 O - 77 - 2

Mr. Kaye died in his sleep one night and, like Mrs. Barth, Mrs. Kaye went immediately to her children's homes—first to her daughter's, then to the son in the neighborhood, and then to the other son's suburban home. Mrs. Kaye said she knew these arrangements were temporary; there was a reason in each family why she could not remain permanently. She and her daughter got on each other's nerves and she actively disliked her daughter's husband. Louis, who lived in the neighborhood, was her favorite child, but his wife worked; their children were grown; and she didn't want to sit all day with no one except the aide. Suburban life was not for her; this daughter-in-law worked also but there were still grandchildren at home. She loved them, but they got on her nerves.

The truth was, Mrs. Kaye told me, that she and Mr. Kaye had been planning to come into the home together. She knew taking care of her was getting to be too much for her husband; he needed care himself. They had not talked to their children about their thinking—primarily, she said, because they were still able to manage. Members of their families were in homes for the aged; their children were active in charitable work, and they assumed (rightly, as it turned out) that when the time came, they would have no difficulty in getting into the home of their choice.

When I interviewed Louis and his wife, their presentation differed from Mrs. Kaye in only two respects. First, they doubted that Mr. and Mrs. Kaye had been planning to enter a home together. They could see Mrs. Kaye doing this; she needed people around her; she was always involved in the lives of her family, neighbors, and friends; like Miss Anderson, her incapacity was clear and made her totally dependent on others. Mr. Kaye was different—quiet, liking people, but not needing them in the way Mrs. Kaye did. He often retreated to his bedroom when the living room was full of family and friends; he valued his privacy too much, Louis and his wife thought, to be able to see himself in an institution. They thought it more likely that Mrs. Kaye, being a realistic, planful woman, had anticipated that she would survive her husband and had begun thinking of the home for herself in the months prior to Mr. Kaye's death.

Second, Mrs. Kaye had presented the reasons why living with her children was not a good arrangement. But absent from her presentation was the agony she and the children had experienced during the months between her husband's death and her entry into the institution. She had left each child's home in anger, after weeks of tension and unhappiness. They were not sure whether she had harbored the hope that she would be able to live with one of her children. They had all offered to make the arrangement permanent, and it was an offer in good faith. But her decision to go to the home came as a welcome relief to all of the family, and there had never been any question in anyone's mind that it was the best arrangement. Mrs. Kaye was happy in the home; she told her children this and thanked them for making it possible. She had maintained a capacity for self-care that was unexpected, and she was as sharp intellectually as she had always been.

The children were proud of the leadership role she played in the home as she had in the community in the years before. And, the tension in relationships which had developed during the year before she entered the home was gone. She still butted in with unsolicited advice; she still demanded that she be included in family decisions. But this was their mother, and, though there had always been some resentment of her attempts to control their lives, they had learned over the years how to deal with her. And they admired her spirit, even if sometimes they wanted—and did—tell her to mind her own business.

Mrs. Porter, on the other hand, was one of the few people in the study who fit Blenkner's and Shanas' description of the older person who interpreted the move to the institution as rejection by her children. She was one of the youngest women in the sample—67 when she was admitted to the municipal long-term care facility and 69 when I interviewed her. Her life had been one of economic deprivation and the poor health which so often is one of the costs of that deprivation. She had diabetes, and in her early 60's one leg was amputated. After months in an acute treatment hospital and then in the rehabilitation unit of the municipal long-term care facility, she had gone to her daughter's to live.

The course of her illness was difficult to track. The medical and social services records at the long-term care facility were sparse and incomplete, and neither she nor her daughter completely understood what had happened or why it had happened. What was clear, however, was that the rehabilitation process had not been

successful. The prosthesis with which she had been fitted had been discarded because "it hurt and I couldn't get used to it." And then when Mrs. Porter was 66, her other leg was amputated.

This time she was discharged from the acute treatment hospital to the municipal long-term care facility, but not to the rehabilitation unit. Rather, she was in a unit which was known by staff, patients and families alike as a unit for "the chronics." She got about in a motorized wheelchair; she was in the physical and occupational therapy programs; but only she seemed to believe or hope that she would be fitted with two artificial legs and be able to walk again.

Her daughter, an only child, was the youngest child in the study; she was in her 30's, the mother of a 6-year-old and a 2-year-old and the wife of a low echelon municipal worker. He worked on weekends as a filling station attendant, and Mrs. Richards, the daughter, who had been a clerk-typist before her first child was born, did typing at home to earn extra money. They lived in a row house in a lower middle-class neighborhood, the first home either she or her husband had ever owned. "In partnership with the bank, of course," Mrs. Richards said, in wry reference to their mortgage and the monthly payments which "leave us strapped."

When I interviewed Mrs. Porter, she presented herself at first as a temporary patient who lived only for the day when she would be ambulatory again and could return to her daughter's home. She would take care of the house and the children so that her daughter could return to full-time employment. She talked about how much help she had been to her daughter in the years between her first and second hospitalization. As the interview progressed, however, other themes emerged. Mrs. Porter didn't think she should be in the hospital now. She thought she should be in her daughter's home and receive the treatment she needed as an outpatient at a hospital in the area where her daughter lived. Her daughter and son-in-law could drive her to the hospital; they could make their dining room into a bedroom for her until she got her artificial limbs and would be able to climb the stairs to the second floor where there were three bedrooms. "The kids don't need separate bedrooms; one of them can be mine."

And as she talked about her plans for the future, her anger at being in the hospital, her feeling that she wasn't getting the rehabilitation services she needed in order to walk again, she expressed her feelings of rejection by her daughter and son-in-law and her rage at them. She felt that she was *entitled* to live with them; she had worked hard all her life. Her husband had deserted her when her daughter was a little girl, and she had supported the two of them and put her daughter through high school. Now it was her turn to be cared for and supported and instead "they dumped me here with all these crazy people and – – – – –." And then she listed racial and ethnic groups represented in the patient population and on the staff. "I don't like them and I don't want to be anywhere near them." There was nothing about the institution which she liked or which satisfied her—her room, the treatment she received, the staff, the food, the other patients.

Her daughter came twice a week to see her, shopped for her, and brought her home-cooked meals. There was a sign as you enter the facility, "No children under 12 are allowed to visit," but Mrs. Richards usually brought the children with her, and their visits took place in the commissary where the rule was not enforced. Her son-in-law rarely came; "He's too busy to care about what happens to me."

At the end of each interview, I asked the old person for permission to talk with a member of her family. Mrs. Porter wanted me to "tell her I shouldn't be here." The social services department had been understaffed for several years prior to my study. There were units, including Mrs. Porter's to whom no staff was assigned, and the director and her workers did the best they could to respond to emergency situations and acute psychosocial problems. The social services records included notation of frequent contacts both with Mrs. Porter and Mrs. Richards; similarly there were notations in the nursing records of the efforts the unit supervisor and staff made to help mother and daughter.

I phoned Mrs. Richards and we arranged for the interview to take place on a Sunday afternoon in the social service offices before she went to see her mother. Mrs. Richards knew how her mother felt: She knew her mother thought she was entitled to live with the Richard's. She thought that "deep down" her mother also knew that the attempts to fit her with the artificial limbs and teach her to get about on them weren't going to work.

> It didn't work the first time when it was only the one leg. I don't know why; sometimes I think Mom just didn't try hard enough.

That's what Mr. Friedman [the physical therapist] says.

But even if it did work this time, I just can't take her home with me. Pete [her husband] and I have talked a lot about it, and I've tried to explain to Mom how we feel. But she just doesn't understand. Miss Allen [the social worker] has helped me and I know she's tried to talk to Mom—but nothing seems to help.

Mom's had a terrible life, you know. My father left and it was just the two of us. She didn't want me to get married—I don't know whether it's because of what happened to her or whether she just wanted to keep me at home. Anyway, she and Pete don't get along, and I'm always in the middle. She talks about when she lived with us after the first operation—she says she helped me with the baby and the cooking and the cleaning. Maybe she did help—it's so mixed up in my mind, but mostly I remember trouble between Pete and her and feeling sometimes as if I had two babies to take care of—Jeannie [her daughter] and my mother. And Pete would come home exhausted—and I was so tired all the time. I just can't go through that again.

I don't know what to do. I *do* love Mom, and I feel so sorry for her. She really had a terrible life and the kids and I are all she's got. But sometimes [a pause and tears], sometimes I just wish the problem would go away. I talk to her about trying to make the best of it here—to try to make some friends. I've watched some of the other people who have friends and keep busy, and I point them out to her. But this just makes her mad.

I come twice a week, and we're taking her home with us for 4 days at Thanksgiving. Pete isn't happy about this—but he understands. She's my mother and I can't forget that. I talked to the social worker about trying to get her into a place she'd like better than this one. There's a nursing home about 10 blocks from my house. It'd be easier for me and it's smaller and nicer than this place. I went there—there weren't any — — — [the ethnic groups Mrs. Porter complained about]. But a lot of the people were there from . . . [a State mental hospital which was transferring many of its aged, mentally impaired patients into skilled nursing homes and other community facilities], and there were a lot of really sick, very old people there. And they don't have a physical therapy program.

I talked to Miss Allen a couple of weeks ago. There are some apartment houses near us. I was thinking that maybe we could get a studio apartment for Mom. We're trying to find out if her Social Security and welfare would be enough, and if the welfare will pay for someone to help her. I'd come every day and do her shopping and things. But Pete says I can't be running over there every time she calls—and we don't know what's going to happen with the legs. One hasn't healed completely yet, and she was never able to get used to the other one.

So I just don't know. All I know is that I feel trapped. I've got Pete and the kids—they're my main responsibility—but I've got Mom, too—and I don't know what's right.

. . . .

I have described these five people and the circumstances of their entries into long-term care facilities in some detail for several reasons. First, each is typical of groups of residents and patients. Two were single, one with a family, and one functionally alone. Three were married and with children; one came willingly to the home; one, against her will; and one, willingly, but in her view, temporarily.

All had health problems; Miss Anderson, Mrs. Kaye, and Mrs. Porter were, in functional terms, the least able to manage for themselves and the most in need of personal assistance, nursing care, and physical therapy. Mrs. Barth and Miss Farrell might have been able to manage in the community—at least for a while longer. Four families were involved in the admissions process, but in different ways. Miss Farrell's relative was totally uninvolved, but her minister played a surrogate family role. Now, as I turn to the *how,* I have five different situations to use as the basis of discussion.

The second reason for beginning in this fashion is that these five people will continue to be used as examples throughout the manual. Clearly all five of them came in at a point of crisis in their lives, and with the possible exception of Miss Farrell, all described the path to the institution in words of pain and sorrow and loss. Earlier I cited Shanas: "Finally, no matter what the extenuating circumstances, the older person who has children interprets the move to an institution as rejection *by his children.*"

This was certainly true of Mrs. Barth, although it should be noted that she said she wanted to remain in her own apartment, not, as is the conventional view, to move in with her children. Mrs. Porter was the one among these five old people, one of the few among the 247 people in

the study, who expressed the feeling that her being in the institution was a sign of her daughter's rejection of her and who clung to the hope of returning to her daughter's home.

Mrs. Kaye's and her children's reports of their feelings were different; Mrs. Kaye says she never considered living with the children; the children were not sure. In any event, the decision to come to the home was hers.

One can question whether what Mrs. Barth and Mrs. Kaye *said* they felt was what they really felt. I can only say that this was the way they presented themselves. At the least, question can be raised about the totality of the Shanas' statement. It is undoubtedly true that there are many Mrs. Barth's and Mrs. Porter's who did see the move to the institution as rejection by children. But there are also many Mrs. Kaye's.

Chapter 2. The Work With Families in Process

I said in the Introduction that a goal in the preparation of this manual was to write it in such a way that it would be useful to staff in a variety of long-term care facilities in the United States. However, not just the facilities themselves are different; the elderly people are. The five people whom you have just met illustrate some of the differences in the kinds of patients and residents and families who come to the facilities and the different paths they take to the doors.

A. Let's start with the ideal situation and then talk about what can be done when the situation is less than ideal and, perhaps, more typical of your work. In many ways, Miss Anderson's entry into the institution was ideal, even though she came in crisis, directly from a rehabilitation center, after a sudden event—the injury, and after months in a hospital and rehabilitation center.

But those months gave her and her family time to adjust to the knowledge of her incapacity and time to think about alternative arrangements. Moreover, she and her family had access to expert advice, from the doctors in her case, from the social services department of the rehabilitation center, and finally from the well-staffed and credentialed department of the home to which she came.

Miss Anderson herself was not able to visit the home prior to her admission. But her family did; her niece, her brother, and a cousin came, not only for the routine social service interview, but also to get a sense of life in the home and the people with whom Miss Anderson would be living. They knew from their doctors and the staff at the rehabilitation center that the home had an excellent reputation for the quality of its medical, nursing, and paramedical services.

> We trusted Dr. . . . . He's been our family's doctor for years. Besides we're not doctors; you just have to take the doctor's word. But what we really wanted to see—and talk to my aunt about [the niece told me] was the atmosphere of the place and the kind of people who lived there. They let us walk around, and the social worker introduced us to two patients whom they thought my aunt would have a lot in common with. The social worker was right: The two ladies had been career women like my aunt and, like her, they're sick physically but sharp as tacks mentally.
>
> They told us good things and not so good things about the home—but they were comfortable there and thought my aunt would be too. The main thing about those visits, as I look back on them, was that the social workers and nurses and other staff we talked to never questioned our desire to know about the home. We even got to know Mrs. Kee [the receptionist and switchboard operator in the social services department] well during that period, and we always felt that she wanted to be as helpful as she could be, too.
>
> As a matter fact, one of the nurses told me that she wished all families cared as much about their relatives as we did. And that made us feel good.
>
> We were able to describe the place to my aunt and tell her about the people. She was taken there by ambulance, of course, and it wasn't an easy day. How could it be? But I took the day off and went with her and the nurse greeted her by name, and the social worker came right up to her room when we got there. They have a coffee shop so I had lunch there and stayed until late afternoon.
>
> The social worker had asked me how often the family had called or seen my aunt before the accident. That was an interesting question: You know we're a big family and spread out, and I had no real idea how to answer the question. I knew my father and mother and my aunt saw each other two or three times a month; she and I usually had lunch together in the city pretty regularly—I work near her apartment. But I didn't know about the rest of the family, and I didn't really know whether there was a set pattern.
>
> After her hospitalization, of course, we set up a regular routine, so that she would have visitors every couple of days. I explained this to the social worker and she told me some things that I've never forgotten—it's just common sense, in a way, but I think if more families understood this, it would help.
>
> She's been on the staff here a long time, and she said in her experience, it isn't actually how often the family visits or does other things that makes the difference for the patient. It's whether the family continues to

do what they've always done—as much as possible, of course—and whether they do what the patient has expected them to do. The social worker also said that the first few months were very important and that if the family could, they should try to do more than they had before or would be able to go on doing over the long pull. It was hard for me to imagine my proud, self-sufficient aunt as frightened and needing to be reassured that we love her and weren't planning to dump her here—but I know that does happen and that she might meet people here whose families had left them—so we did decide to do what we called "rotate the duty" to make sure my aunt had frequent and regular visits in those first months in the scheduled way.

My dad and I talked to my aunt about it before she came in. You've talked to her and you know she has a marvelous sense of humor. Her first reaction was to laugh: "I sound like a ten year old going to camp for the first time and you and the counselor are afraid I may get homesick." It did sound something like that and we played with the idea for a while, with my aunt and me getting sort of hilarious with the picture of 85-year-old campers leaving from Grand Central.

My father stopped us—I guess it's too close for him, and she's always been his favorite sister—and he's never had her sense of humor. Anyway, we had a serious talk then—that's when we decided she should have her own phone next to her bed—and that was one of the best decisions we ever made. And I must say I learned a lot about my aunt and what was important to her. I hadn't really realized how important her cousins in Massachusetts are to her; they're not particularly close to my folks. I knew my aunt and they visited back and forth, but I didn't know they talked by phone every Sunday.

I did something I've never told her about. I wrote or called the people she talked about that day—including the women she had worked with. I went through her phone book at the apartment, and sent out those change of address and phone number cards that you can buy and added a note from me, saying that the person I was writing to was important to my aunt and we hoped they'd be able to keep in touch. Some of them wrote to thank me for thinking of them and almost all of them have written or called or visited. Some of them are dead now, of course; and two of her oldest friends are also in nursing homes.

She does get depressed sometimes—I don't know whether she told you that—but it's because she hates being so restricted and dependent on others—and I guess because she is old, and sometimes she must think about dying. But one thing—she never feels that we and the friends she was really close to have forgotten her.

Let's examine what makes this an ideal situation. Miss Anderson, herself, is a special kind of person. The fact that she is still surrounded by family and friends tells us that she had always invested herself in others, and the bread she cast upon the water is now coming back to her when she needs it. She is fortunate also: Her family and friends are people of means. They can afford to pay for her private phone. When I interviewed her, the Massachusetts cousins had just left, having spent several days in New York, "doing the theater and museums" and visiting Miss Anderson. Miss Anderson is lucky also in a way that all of you will understand: There is no evidence of organic mental syndrome so that a visit with her is a time of pleasant, stimulating, and humorous conversation.

All of these things about Miss Anderson herself and her family and friends are important. But what made this an ideal beginning was the way the social worker and nurses worked with the family.

First, they accepted the *right* of the family to decide whether this was the home for their relative and *understood* their need to know more about it. It wasn't just that a brochure said "visitors are welcome," nor was it just what the staff said. They behaved in ways which reinforced their words; they introduced the family to other patients and spent time themselves with the family.

Second, the staff asked about the family composition—who they were, where they were, what the customary pattern of contact had been. The messages the staff was delivering even before Miss Anderson came in were clear:

1. The home was interested in Miss Anderson's family and friends. Miss Anderson was not seen apart from the people who had been her life before her accident.

2. The interest was purposeful. Questions were not just being asked for the sake of asking, but in order to help Miss Anderson and the family. The securing of the phone was an example; in the process of talking about Miss Anderson's customary pattern of maintaining contact with her family and friends, the importance of the phone became clear. And the

family's opportunity to observe life on the unit made them realize that Miss Anderson and her family would not be able to have their frequent phone conversations if Miss Anderson were dependent on someone else to get her to the phone, or if she had to share the phone with others.

3. Perhaps most important, from the beginning, the staff made clear the partnership between institution and family and friends. The emphasis on the first few weeks was one way in which this partnership was articulated. Both the staff and the family knew that this was a time of crisis for Miss Anderson. Their goal—helping Miss Anderson through this period—was the same, but there were tasks which the family could perform best, and similarly the institution was better able to do other things.

Examples of this are obvious to you who each week help old people and their families through the admission process. The room was ready; Miss Anderson's name plate was already on the door and over her bed; a volunteer came with a corsage, her roommate had been prepared; the nursing, dietary, and physical therapy departments had the information they required to begin her regimen of care; the letter from the executive director welcoming her to the family of the home was on her bedside table. The social worker had been assigned and had blocked out time in her schedule so that she could spend time with Miss Anderson and her family that day. The financial arrangements had been made and all the forms completed by the business office and ready for signature.

All of these were, in Litwak's terms, *uniform* and within the province of the institution. But the family had its tasks to perform also; Miss Anderson had always been a proud and stylish woman with strong preferences about clothes and makeup, etc. Her niece and one of her friends and she had gone over what she would need and want: no frilly bed jackets for her, but tailored night gowns and robes and her makeup kit and a hand mirror.

They knew the photographs she would want with her and the importance of the plaque she had received at the time of her retirement. They made arrangements for her magazine and newspaper subscriptions. They knew also that she hated corsages and cut flowers, but loved African violets. Miss Anderson was a lady so she accepted and wore the corsage from the volunteer, but it was the African violet plants that her friends had delivered to her room that, she remembered in our interview, helped make her feel "still like a person—not just a case."

Her niece had included also stationery, stamps, postcards, her pen and pencil set, and a box of thank-you notes. That box of thank-you notes had special meaning which only her family and friends could know: Miss Anderson had been raised in a genteel tradition. Gifts were to be acknowledged immediately and in writing. The inclusion of the box in the belongings she brought with her that she would continue to be able to observe this amenity—and also that there would continue to be gifts for which thanks would be due!

These familial tasks were *nonuniform*. The family was beginning the process of meeting Miss Anderson's idiosyncratic needs. They were making provisions for her beyond that which the institution could do for each of its more than 700 residents and patients. And they were *experiencing*—not just reading about or hearing about—the partnership between the institution and them.

B. Now let's take a situation which is less than ideal because of the circumstances of the patient's arrival and his family situation. Mr. Randolph came into a 100-bed proprietary nursing home directly from a municipal acute treatment hospital with which the nursing home had a transfer agreement. He had been found wandering on the street one day and had been taken by ambulance to the hospital where he had remained for 4 weeks.

Mr. Randolph was brought to the nursing home by ambulance, accompanied only by the ambulance crew. The hospital records which the crew gave to the administrator included notation of the circumstances of his hospitalization; the results of the diagnostic workup; the medical and nursing regimen that had been followed; his physical condition at time of discharge; and the regimen to be followed in the nursing home.

There was no real social history. While the date and place of his birth were there, there was nothing about his occupation or family. His address was recorded and in the section marked "person to be notified" were the name, address, and phone number of the woman who owned the boardinghouse where he lived. There was nothing to indicate that she had been notified when he was hospitalized or that she had been contacted during his time in the hospital or at the time of his transfer to the nursing home.

He was admitted to the nursing home within 48 hours after the social worker at the hospital had phoned the administrator about him. All that the nursing home staff knew was that a white male, age 71, organic mental syndrome, severe, Medicaid patient, was to be admitted and that he had "derived maximum therapeutic benefit" from his hospital care, but would continue to need skilled nursing care.

The nursing home was a small one, and the elaborate system of interdepartmental written communications, required in the large institution to which Miss Anderson had been admitted, had not been developed. There was an empty bed in a double room; the other patient was Mr. Landau, about Mr. Randolph's age, who had Parkinson's disease. The day before Mr. Randolph was to be admitted, the administrator, the director of nursing serivces, and the social worker/activities worker got together, made the decision about the room assignment, and notified the chief dietician, head housekeeper, and the chief nurse on the unit. The social worker went up to see Mr. Landau to tell him that Mr. Randolph would be coming in the next day. Mr. Landau was married and his wife lived in the neighborhood and came daily to help her husband eat his lunch, wheel him to occupational therapy, and talk with him. It was important that Mrs. Landau know about Mr. Randolph's arrival, since Mr. Landau had been alone in the double room for over a week and Mrs. Landau was beginning to think of it as her husband's own private room.

When Mr. Randolph arrived midmorning, he was taken immediately to his room and settled in his bed. He was unresponsive to the nurse's efforts to greet him, to introduce him to the Landau's. It was hard for the nurse to tell how much reticence was due to Mr. Randolph's physical and mental condition, what kind of a person he was, or how much was "transfer trauma."

Meantime, the relevant sections of the hospital records were being xeroxed: one copy for the office; one for the nursing station; one, for the dietician; one, for the social worker. He had come with a small, battered suitcase which had in it, in addition to some clothing and toilet articles, a transistor radio, a clock, and an address book. His wallet was there, too, his Social Security and Medicare cards were in the wallet and an identification card on which was written the name, address, and phone number of his landlady. The address book—the kind you buy in a dime store—was an old one: There was little in it—most of the names had been crossed out, but one caught the administrator's eye. It was Mary Randolph. There were several addresses and phone numbers—all crossed out, but the last one—not crossed out—was a ward number and building at a State mental hospital.

The nursing home staff, of course, would have preferred an intake process like that of Miss Anderson's. The absence of the opportunity for such a process and the inadequacy of the hospital records were, however, nothing new to them. Although they complained among themselves about the failures of the hospital staff, they knew also that the social services department of the hospital was severely understaffed. And they knew also that patients like Mr. Randolph—with no family to intercede in his behalf, viewed by many on the staff as a "simple senile" who required "only custodial care"—were seldom assigned priority.

The nursing home staff was also overworked. There were certain clear-cut task assignments, but many of the staff were, in the words of the social worker/activities worker, "jack-of-all-trades" or, as the administrator put it, "We all pitch in where we're needed." In the early weeks of Mr. Randolph's life in the home, the most important tasks were to complete the paper work necessary for reimbursement to be certain that the "basic maintenance and medical and paramedical services"[1] that he needed were being provided, and to work with the Landau's. As the staff had feared, Mrs. Landau in particular resented Mr. Randolph's presence and regarded him as an intruder in her husband's room. Her complaints to the staff were frequent and handling them, time consuming, but the staff of this nursing home—like the home to which Miss Anderson had come—had a philosophy of care which included "work with families." And they were touched by Mrs. Landau's faithful care of her husband, albeit there were days when they wished she were not quite so faithful, when demands she made on them seemed excessive. It remained hard to tell how much Mr. Randolph understood about where he was; he did what was asked of him and didn't cause anyone trouble. The nurse's notes at the end of the first week included, "Mr. Randolph seems to take each day as it comes—without question or

[1] Brody, Elaine, *Ibid.* p. 91.

objection. He seems to like his radio, and when he is taken to the Lounge, he remains in front of the TV until he is returned to his room. His appetite is good, and he sleeps both during the day and at night."

Staff talked with him; he was affable, but his memory was hazy and his attention span limited. So staff questioned him little about his life before he came to the nursing home, which he called "the hospital," and mostly conversation was about the daily routine. It was several weeks before anyone had time to try to find out more about Mr. Randolph. One Sunday morning the administrator, director of nursing, and social worker were talking: the social worker had some time before the afternoon program began and there were no emergencies. So she called the landlady whose name had appeared in the hospital record.

The landlady had wondered about Mr. Randolph. She had been called when he was admitted to the hospital and it was she who had gathered up his belongings and brought them in his suitcase to the hospital. She had seen him then; he didn't recognize her and the nurse had told her that he would undoubtedly be sent to a nursing home. They had called her once more to tell her which nursing home.

The landlady was relieved that "the hospital had taken over." Mr. Randolph had lived in her home for several years—she didn't remember just how long. He was a handy man and painter, didn't work regularly, but always paid his rent on time and, up to the last few months before he went to the hospital, hadn't caused trouble.

Then he had begun "acting strange" and several of her other tenants had complained. He played his radio late at night and talked to himself and sometimes pounded on the doors of the rooms near his. She had spoken to him about this; "I figured he was going senile and I was going to have to do something." But then he had been picked up and taken to the hospital so "it wasn't my worry anymore."

The landlady didn't know much about his family: He had told her that he had been married years ago "but it hadn't worked out." But the landlady did know who the Mary Randolph in his address book was. One Christmas, a couple of years before, she had met him in the hall as he was leaving the house with some packages in his arms. Maybe it was because it was the Christmas season, but for the first time Mr. Randolph told his landlady about his daughter who had been in and out of the State mental hospital for several years. She was the only family Mr. Randolph had in New York. He hadn't been a good father to her; he had deserted his wife and small children. He thought the rest of the family lived in California somewhere.

The landlady didn't know how Mary and her father had found each other; all she knew after that Christmas Day was that Mary was his family and that he visited her at the hospital regularly. The social worker asked the landlady if she was interested in visiting Mr. Randolph, explaining again that her name appeared on the hospital, and now the nursing home, record. No, the landlady had her own problems; her name was listed because Mr. Randolph's rent was paid in advance and she had held the room for him that month and then turned his belongings over to the hospital. She felt sorry for Mr. Randolph, "but there're a lot like him in this city, and he's lucky he's where he is."

The social worker wrote notes on the conversation and later in the day she and the administrator agreed that she should contact the State hospital. By this time, I think you who have known and cared for many Mr. Randolph's understand how the staff felt. Mr. Randolph was no longer just the nontroublesome, nice patient in C-13 or Mr. Landau's roommate, or "the OMS" who came in from a hospital in November. There was a life history to be understood for there was someone who had been important to him, and maybe—just maybe—Mary and her father might still need each other and love each other. The call to the State hospital was made first thing Monday morning: it was Wednesday before the social worker there could track down the information. Mary was living in a halfway house operated by the hospital. She still returned to the hospital once a week, and she wasn't working yet. But she had been "out" for 3 months with no sign of trouble.

The hospital social worker knew from the record about her that Mr. Randolph was listed as next of kin and that he did visit her. The hospital records were not complete; the social worker was new to the case. There was no notation indicating that the staff were aware that Mr. Randolph had stopped visiting or that any attempt had been made to contact him then or when Mary was transferred to the halfway house.

The hospital and nursing home social workers agreed that they should talk with the hospital

psychiatrist before anything else was done. The hospital's treatment goal was to help Mary make it as long as she could in the community: She was getting along well with the other patients in the halfway house and was less frightened of traveling between the house and the hospital and doing some of the marketing for the house. But her hold on reality was tenuous the prognosis, guarded at best; and there was no staff member in the hospital or the house who knew where Mary's father was in her mind and heart.

The psychiatrist was consulted: What a good and modest professional he must have been! He had only known Mary since she had been in the halfway house; their time together was regular, but brief, and it was spent in checking the psychotropic drugs she was on and reviewing the events of the past week and the goals for the next. He didn't know how she would respond to being told about her father, but he thought it was worth the risk, and, best of all, he would take responsibility both for the decision and for talking with Mary.

Mary's troubled life history had taught her the saddest of all lessons: never to count on anyone or to hope that today's happiness would last. Her father's early desertion and then occasional phone calls and letters, followed by long periods of silence, had been part of this painful education. She told the doctor that, when her father began visiting her in the hospital, she was happy, and, even when the visits were regular for months and months, she welcomed each one but never let herself hope for another one. She had at least learned not to blame herself, not to wonder what she had done that made him stop coming. And she also knew he was the way he was; it wasn't his fault.

This was how she had figured it out, and, even after she was out of the hospital, she said, she hadn't thought about trying to call him or that he might be ill and not able to visit or write her. The doctor explained where her father was; that his memory was not good; that, if she visited him, he might not recognize her or remember that he had a daughter. Could she stand that?

Since Mary was a veteran State hospital patient, she knew many people like that. It wouldn't frighten her or surprise her, although he *was* her father and she would be sad to see him that way and to have him not know her. But maybe seeing her would help him, and they were all each other had.

Mary visits regularly now—every Sunday afternoon, the way her father visited her. He always recognizes her as someone he knows; most of the time he knows she's Mary, his daughter, but sometimes he gets mixed up and thinks she's his sister. No one knows how long it will last, and Mary is still in the halfway house, still afraid to think about trying to work again.

Mr. Randolph clearly enjoys getting dressed up on Sunday's, and he likes going to the Sunday afternoon refreshment hour with Mary. Diagnostically he's pretty much the way he was when he came in. Maybe Mary's visits have slowed the process of decline; he sleeps less in the daytime than he did. But no one can really say. Two things are certain, though: Mr. Randolph is a person to Mr. and Mrs. Landau, particularly to her, and the roommate situation is now no more difficult that the usual. And second, the staff feels that the reunion of Mary and her father is a success story, all the more so because of the circumstances of Mr. Randolph's admission and his family-life history.

I have told the story in detail because Mr. Randolph's situation is somewhat typical and because the nursing home in which he lives did not have fully staffed departments. What it did have, however, as I have noted before, was a philosophy of care which included the families. The staff knew, in the words of the administrator:

> There is only so much we can do. Families like Mrs. Landau give us trouble sometimes, but I've been here 20 years and I know—the trouble is almost always worth it. The patients need their families and so do we.

C. One more example of the beginning relationship between staff and family can be told with less detail because you've already met Mrs. Barth and know the circumstances of her admission and how she and her son look back on it. The home to which she was admitted had a fully staffed and highly credentialed social services department. It had a waiting list, so there were, with rare exceptions, at least several months between application and admission.

An intake worker was immediately assigned to each family at the point when the formal written application was received, and the worker saw both members of the family and the old person a minimum of at least twice during the application process. There were forms to guide the intake worker at the time of her initial interview and for subsequent contacts between that

first interview and the day of admission. Suggestions about the protocol for recording the intake process are included in the Appendix to this manual because, as I completed my study, it seemed to me that there were additional content areas that were important but that had not been included in protocols I knew about in New York City or in the Brody publication.

I have also included in the Appendix copies of the application for admission and a number of the forms used in the intake process in one long-term care facility in New York—the one to which Mrs. Barth came. As you will see when you review this application and the other intake forms, there is considerable attention paid to family composition and relationships during the intake process, and then provision is made for transmission of relevant information to other departments in the facility.

Mrs. Barth's situation was, therefore, unlike Mr. Randolph's in that there was an intake procedure, ideal in the time provided for it, and a staff assigned to help Mrs. Barth and her family. Unlike Mr. Randolph, without her or her family's knowledge she was not transferred from one facility to another. On the day of her admission, the home staff was not confronted, as was the staff who greeted Mr. Randolph, by a new patient about whom they knew almost nothing and who could tell them little.

Moreover, Mrs. Barth was different in an important way from any of the other people whose stories have been told. Yet she is no stranger to you; you work with Mrs. Barth's and their families all the time and they present some of the most painful and difficult challenges you face.

You will remember that 5 years after Mrs. Barth's admission, when I interviewed her and her son, she said that she still felt that she should have *been permitted* to remain in her apartment, and her son, knowing full well how his mother had felt then and how she still viewed the situation, nonetheless stated his belief that the decision which he and his brother had made had been for the best. The notes of the intake worker, written at the time of Mrs. Barth's application and admission, testify to the pain and uncertainty she experienced.

Mr. Barth had made the initial call and had been sent the application material. He explained in an early phone conversation with the intake worker that his father had recently died and that his mother was at his home. He told the worker that he and his brother and the rest of the family didn't think his mother would *ever want* to come to a home, and he explained why the family thought this was the best arrangement.

The question was how to convince his mother. The worker wrote:

> I told Mr. Barth that this was not an unusual situation and that we had found that if the family moved slowly, gave the mother a chance to think and talk about it, and explained to her their reasons it often helped. I told Mr. Barth about our Sunday open houses and guided tours for prospective applicants and their families and suggested that this might be something the family could do.
>
> I said I could understand their concern about her health and her being alone so much, but I also questioned whether maybe they might not be moving too quickly. It was such a short time since Mr. Barth Senior had died.
>
> Mr. Barth knew this; he and his brother and everyone in the family had talked it over. But they had decided even before Mr. Barth's death that the home was the best place for both his father and his mother.
>
> Now with his father gone, they were even surer. Ours was the home they wanted for her; they knew how good it was. They contributed money to it each year through one of Mr. Barth's friends who was on the Board. And it was right on the way from Mr. Barth's office and home so he could visit frequently.
>
> They knew our admissions policy and were afraid that if they waited, Mrs. Barth wouldn't be well enough to be accepted. And they knew also about the new building and wanted her to have a room there before it got full. Even in his house, she was alone too much, and they were afraid she would go down hill the way they had seen others do.
>
> Then Mr. Barth said, "Mom will do what we think is best. She's always been that way. We just want to make it as easy for her and us as we can."

This was the end of the notes, and the next recording was of another phone call a little over a week later. Mr. Barth and his brother had brought Mrs. Barth to the home that Sunday and had shown her rooms in the new building. They had gotten her to sign the application form, and Mr. Barth was dropping the completed forms that afternoon on his way home. He hoped the first medical and social services appointment could be scheduled soon.

The appointments were scheduled for 2 weeks later. Mrs. Barth was accompanied by both of her sons and her daughters-in-law. One daughter-

in-law remained with Mrs. Barth while she was being examined and the rest of the family came to begin the social service appointment. The worker described the family—they were good-looking, well-dressed people in their early 50's, articulate, poised, not entirely comfortable, but with the tension that is to be expected.

> Richard, the oldest and also most affluent son, took the lead, but all three participated. There was no sign of disagreement among them; they had given careful thought for some time to what arrangements should be made for their parents. They knew about senior citizens hotels, and in fact one daughter-in-law's mother was living happily in one of them.
>
> "But she's different than Mother Barth," the daughter-in-law said. "My father died when she was in her 60's and she was still young enough to make a life for herself. And she was always more social—she played cards and had a lot of friends and used to go to Florida every year. And she's healthier than Mother Barth, so the hotel is fine for her, because she really doesn't need much help.
>
> "But Mother Barth wouldn't like the hotel any better than here, and she wouldn't get the care she needs. I've seen people like her; they just sit in their rooms and they end up in a place like this anyway."

The worker noted further:

> I asked about other alternatives—the possibility of delay, of trying out her returning to her apartment with a part-time companion, etc.
>
> The three exchanged glances among themselves, and there was silence for a moment and then Michael spoke. They understood I was doing my job. They knew Mrs. Barth didn't want to come to the home. But I had to understand; they love her; they're not planning to dump her on us. But they really have thought for over a year now about what was best. There are also other people—the one daughter-in-law's mother in the hotel and the other daughter-in-law has both her parents. They're all okay now, but they're old, too, and the family has them to think of. There are all their children too who still need help. All four are working hard, and then Richard spoke again. "Mom just doesn't realize how many demands she makes on us—the shopping that can't wait, the doctor's appointments, and the phone calls—at 11 or 12 at night—sometimes at 6 in the morning. That's been going on for a year or so now."

The clinic nurse called to say that Mrs. Barth had been medically approved for the maximum personal assistance unit in the health-related facility and that she and her daughter-in-law were on their way to the worker's office. The recommended placement within the home was a kind of confirmation of the family's view of Mrs. Barth's inability to live alone or even with daytime help. And it added reality to their concern about whether she would be able to be medically approved for admission to this home if they waited much longer.

The worker wrote:

> Mrs. Barth is a tiny, frail lady. Her face is sad and tears come easily, particularly as she talks about her husband and their apartment. She reached out to touch her sons and daughter-in-law, and Richard helped her into the chair by my desk.
>
> I went out to get her some tea, and also give her a few minutes alone with her family. When I returned, I said to her that I had gotten to know her family, except for her daughter-in-law who had been with her. Now I'd like to get to know her. Did she feel well enough to talk for a few minutes?
>
> She looked appealingly at her family; they were moving toward the door. All touched her as they left, and Richard reminded her that she had just gone through the waiting room right near my office where they would be.

The worker recorded their talk; it was as Mrs. Barth remembered it when I interviewed her 5 years later. She wanted more time and then she would be ready to return to her apartment with a lady to clean and shop for her. She wasn't sick, only weak and tired now because of her husband's recent death. Mostly the worker listened, and then, because Mrs. Barth had had a long morning and was obviously very tired, she suggested to Mrs. Barth that they stop now and make another appointment.

The worker and Mrs. Barth went to the waiting room; the worker said she thought that it would be best if Mrs. Barth and whoever could come on another day.

> I knew this was an inconvenience and the family wanted a decision then. It could have been done, I think, because Mrs. Barth feels like the kind of woman who lets her family decide things for her.
>
> But I thought it was too soon for her, and that her sons in particular, will feel less guilty if they don't push her so hard right now.

When I said that another appointment would be better—that Mrs. Barth was so tired—the children looked annoyed. But Richard said it was all right, and we made an appointment for the following week.

This time the worker saw Mrs. Barth alone first. It was early in the morning and Mrs. Barth seemed stronger and more able to talk.

We covered much the same ground as we had before. I had talked to the doctor in the meantime about how realistic Mrs. Barth's hope to return to her apartment was. Dr. Goodman said that with Mrs. Barth the problem was more psychological and social than medical. The course of her heart disease was unpredictable; she could have a fatal attack tomorrow or she could live for many more years. The rheumatism was painful, but not disabling—although between the two conditions, she couldn't do heavy cleaning, climb too many steps, or walk long distances.

But Dr. Goodman felt the overriding problems were dependency and loneliness and fear. She needed people around her and the assurance of help whenever she needed it. "Life didn't prepare her to live alone, and she's a smart woman and she knows this about herself—even though she won't admit it."

With what the doctor had said in mind, I told Mrs. Barth of the doctor's judgment that she needed the kind of security the home could provide. As he predicted, she denied this, saying all she needed was help with laundry, heavy cleaning, shopping, and getting to her clinic appointments.

We went round and round about this. I did ask her about living with the children and this she flatly rejected. She had friends who had done it: "No matter how much the children love you and you love them, it starts good and ends bad. I have good sons and daughters-in-law; they'd do this for me—but, never. I'd rather come here or die alone in my apartment than that."

Finally after a lot more talking, I said, "Mrs. Barth, your family really worries about you [and I listed what they had talked about]. They think this is best for you. Could we talk about what it is about the home that you don't like?"

Oddly there weren't many things. Mainly Mrs. Barth didn't like many people besides her family. She got along all right; she didn't fight or anything, but she liked her privacy. And she wasn't sick—that was the main thing—she didn't need a place like this and she wanted her own apartment.

The worker summarized what they had said and then suggested that Richard come in, and she told him what they had talked about with Mrs. Barth nodding agreement and, according to the worker's note, looking anxiously all the while at Richard's face.

There came a moment, [the worker recorded] when Mrs. Barth gave in—and all three of us knew it. Richard had been talking about what a good mother Mrs. Barth is and how much they love her. He reminded her how often they visited Mr. & Mrs. Barth and how many weekends Mr. & Mrs. Barth had spent at his or his brother's house.

He said that wasn't going to change and that one of the reasons they had chosen this home was so he could drop by on his way to and from the office. He said they worried all the time about her and if they knew she was here, then they wouldn't have to worry so much. "We love you, Mom, and we want the best for you and this is the best."

There were tears in his eyes and Mrs. Barth was crying. Mr. Barth got up and hugged her, and I went out and got coffee and tea for all three of us.

We didn't talk much after that. Mr. Barth knew the procedure and that it would be several weeks before we called Mrs. Barth to come look at available single rooms. And all three of us seemed drained.

As I walked them to the door, I asked Mrs. Barth how she felt. She was quiet, clinging to Richard: "What's done is done," was all she said.

The intake worker's notes include her contact with the entire family when they came to choose Mrs. Barth's room.

We are all sitting in the room Mrs. Barth had chosen. Her daughters-in-law were figuring out where her TV and radio would be placed. The children kept asking her preferences, but she would say, "whatever you think."

Someone said something about the closet not being large enough for Mrs. Barth's wardrobe. I agreed and said that we did have storage space for out-of-season clothing. Where families could, we thought, though, it was better if these clothes were kept at one of the family's houses.

Richard said, "That's what we'll do, Mom. We'll take good care of your other things and we'll shift stuff back and forth as you need it. You'll be coming to our house for weekends often, so it won't be any problem—and we have the space."

They had also already made arrangements for Mrs. Barth's phone, and Michael, the son, said, "You know, Mom, I want to talk to you every day or so the way we've always done."

I picked up on that and said it might help if we knew what their schedule of visiting and phoning had been so we could make sure that it remained that way. There were some policies about people being away from the home for more than a day that they needed to know so they could plan.

The one problem that we foresaw was the family and Mrs. Barth's wish for her to continue to see her own physiatrist. I explained that complete medical care was provided at the home—including physiatrics and physical therapy—and that it seemed to work better if our medical staff took full responsibility.

This upset Mrs. Barth. I felt uncomfortable because I knew that our doctors don't like this kind of arrangement. Richard's wife saw my hesitation and Mrs. Barth's upset; and said that maybe she could talk to . . . , the member of the board whom the family knows, and it could be worked out. Everyone nodded, and quickly went on to something else.

The other interesting family discussion was about a big family party, coming up the week after Mrs. Barth is scheduled to come in. One daughter-in-law thought it might be better if Mrs. Barth's admission were deferred until after the party "to make things easier."

Mrs. Barth said she didn't think she should plan on coming to the party. She moved her hands in a helpless sort of way and said something about everyone would be so busy and coming to get her would just be extra work and worry for them.

Richard put his hand on her arm. His voice changed — I had not heard him speak to his mother like this. It wasn't hostile, but there was anger and he was very firm. He said "Mom, you're not going to do this to us. You're coming here on . . . , and the Saturday before the party I'll pick you up and you'll sleep over and I'll bring you back after the party Sunday night or on Monday on my way to work."

Mrs. Barth said something like whatever you want, and the moment passed. The others looked relieved and I saw the two daughters-in-law look at each other and one shrugged her shoulders.

Later when Richard and I were alone, I brought the subject of the party up. Richard said his mother had always been like this: she had always depended on his father and him, as the oldest son, to make decisions. She always had said she didn't want to be a burden—that what she wanted wasn't as important as what the family wanted.

"But Mom's an expert — when she wants to, she lets us know she's sacrificing herself to us. She can make us feel good and guilty, and somehow a lot of times, she gets her way —but it doesn't look like she did anything.

"On the party—she was just making it hard for us. Even if she were in her apartment, I'd still have to pick her up and everything. She just was reminding us that she didn't want to come to the home, and maybe punish us a little by not coming to the party.

"But we can't let her do this—it took me a long time to learn what she was doing and how to handle it. It wouldn't have been good to postpone her coming in until after the party. She and the rest of the family have to see that she's not shut up in here."

The worker's notes concluded with her assessment of the family situation and recommendations for the plan of care for Mrs. Barth. The assessment included the notation that Richard was clearly Mrs. Barth's key relative but that staff should be alert to the necessity to include Michael in the plan also. The worker thought that the family party was very important and that staff should be alerted so that there were no institutional obstacles to Mrs. Barth's going.

The social services records from that time included memos to other departments informing them that Mrs. Barth would be away for 2 nights; to pharmacy to make provision for the medication she would need; to the aide to make sure that Mrs. Barth had any help she needed in getting her clothes ready, etc. There was a handwritten note from the worker to her supervisor:

> I'm afraid Mrs. Barth may find some reason not to go. We've got to be sure everyone understands how important it is.

There were the notes from the case conference held a week after Mrs. Barth's admission. The plan included trying to get Mrs. Barth to come to the new residents group and to go to arts and crafts. She was seen by staff as quiet and depressed and living only for visits and phone calls from her family. The party was discussed; it was reported that Mrs. Barth had told staff that she didn't feel well enough to go; that it was too much trouble for the children; that it didn't really make any difference if she was there.

The staff plan was to provide support to the family; to help Mrs. Barth see that she had not been abandoned by reminding her of how often the family was at the home (daily in those early weeks); and for the worker to talk with the two brothers about how staff might help.

Mrs. Barth *did* go to the party; she did not join the new-residents group. And, as we saw when we first met her and her son 5 years after she entered the home, she never became a real participant in the community of the home.

It was hard for me, after I interviewed Mrs. Barth, her son, and the social worker, and read the record of her 5 years in the home, not to agree with Richard's judgment—that, although Mrs. Barth is not happy at the home, she probably couldn't have been happy anywhere after her husband died. My own guess would be that her relationships with her family during the 5 years are closer and have less tension than if she had remained in her apartment. There have been no midnight calls; she and they know that she is being well cared for in the home, and that the family continues over the years to do the things for her that families do best.

To summarize what I think are the important considerations for staff in beginning the work with families let me say first that the time of entry must be recognized as a time of crisis in the family. But part of the task of the worker and the family, including the old person, is to understand and deal with the particularities of the crisis. Mrs. Barth and Mrs. Kaye were alike in that the immediate event which precipitated the application process was the death of a husband; they were alike also in the fact that their health had been slowly declining over a period of years.

They were different, however, in what they said they wanted their families to do and in their view of the institution. The fact that Mrs. Kaye had thought seriously about coming to the home and viewed this as her own decision made the worker's role with her family and her quite different from the work with Mrs. Barth and her family. I have not presented the record of the work with the Kaye's: The worker did not try to slow down the process as Mrs. Barth's worker did; she and Mrs. Kaye and her family did not think it necessary to explore the possibility of alternative arrangements. Nor, in fact, was it necessary for staff to help Mrs. Kaye or her children work through unresolved feelings about the decision. Resolution had been achieved before the application was made, and, although the Kaye's, like the Barth's, had feelings of sorrow and loss, they needed less support through the application time and Mrs. Kaye's early weeks in the institution.

From the process of getting to know each family came two different plans of care and work with the families.

Mrs. Porter was like Mrs. Kaye and Mrs. Barth because she, too, had a family—her daughter, son-in-law, and grandchildren—and her family was nearby, with a history of mutual responsibilities and demands. Like Mrs. Barth, Mrs. Porter did not think she should be in the institution; but unlike the other two, Mrs. Porter felt—and still feels—that she should be in her daughter's home.

The crisis which precipitated her entry was different. It was an abrupt and traumatic change in her functional health status—the amputation of her second leg. She came directly from the acute treatment hospital to the long-term care facility. Functionally her health status was similar to Mrs. Kaye's, but, unlike Mrs. Kaye (and Miss Farrell and Miss Anderson), she could only accept the reality of her need for the institution for a limited period of rehabilitation.

Mrs. Barth, Mrs. Kaye, and Mrs. Porter were husbandless at the time of admission. What Mrs. Porter's daughter said shows how important it is for the staff to know the family history if they are to make an accurate assessment on which to build a plan of care. Certainly the facts that Mrs. Porter had been abandoned by her husband; that she and her daughter had for some years constituted a dyad; that she had not wanted her daughter to marry and didn't get along with her son-in-law are essential to the staff's understanding of and work with Mrs. Porter and her family.

It is only in the context of this family history that the staff can fully understand Mrs. Porter's feeling that she is *entitled* to live with her daughter: her denial of the extent of her incapacity coupled with her perception of the household and personal assistance arrangements that her daughter should make for her. The dining room could become her bedroom; her daughter could drive her regularly to the hospital for her treatments; her grandchildren's claim to separate bedrooms was secondary to her right to have a room in her daughter's home.

Her daughter's feelings of being trapped are also more clearly understood within the context of this family history. But, there was other

information about Mrs. Porter's family which was necessary to the staff's understanding and ability to be helpful. First, Mrs. Porter's daughter, Mrs. Richards, and her husband and children were at a different stage in the life cycle than were the children of either Mrs. Barth or Mrs. Kaye. Mr. and Mrs. Richards had small children, and Mrs. Richards' feelings of being trapped were part both of her sense of obligation and closeness to her mother and of the young ages of her children, still not in school. Caring for them, being a wife, contributing to the family income by her part-time work at home, doing her housework, shopping, cooking, Mrs. Richards had a heavy load to carry in managing what she—and society—defined as her main responsibility. Aside from the emotional tension which Mrs. Porter's presence in the Richards' home had generated, Mrs. Richards clearly could not, by herself, care for her incapacitated mother except at the expense of her own health and her ability to be wife and mother.

It was also important that the staff, as they tried to help Mrs. Porter and Mrs. Richards, know something about the Richards' economic status. In the days before the abolition of filial responsibility, the securing of detailed and verified information about the income and assets of children was mandated by law. Today, asking for that kind of information would be a violation of the rights of the children, for they are not legally responsible for the financial support of their parents.

Yet, the information which Mrs. Richards volunteered to the staff and to me in our interview was important for the staff to understand: The Richards were just barely managing financially and their ability to help Mrs. Porter was limited. Some of the alternative arrangements which Miss Anderson and her family explored, or which the worker suggested to the Barth's, were impossible for Mrs. Porter and her family. The Anderson's could afford to think about paying for a full-time aide for Miss Anderson. The Anderson, the Barth, and the Kaye families all had large homes with extra bedrooms.

The Richards could not afford to pay for the personal assistance which Mrs. Porter needed; Mrs. Richards could not—day in and day out—provide that assistance herself without damage to her ability to be wife and mother; making the dining room into a bedroom for Mrs. Porter represented a sacrifice of the family life which the Richards' were struggling to achieve for themselves and their children.

Families differ among themselves not only in where they are in the life cycle and in what their financial resources are. *Resources* also include *people*: how many family members there are who can be counted on to help. Again the Anderson's, the Barth's and the Kaye's were families. The Kaye's spoke of "rotating the duty," that is, the children took turns helping their parents during the last year of their father's life. There were three children, their spouses, and several grandchildren nearby, so that, although Mr. and Mrs. Kaye needed regular help, no one person had the daily responsibility.

Mrs. Richards, on the other hand, was an only child; her husband held a full-time and a weekend job; Mrs. Richards had no siblings or nieces and nephews or cousins who could help out, and her grandchildren were too young. Mrs. Richards' description of the time Mrs. Porter lived with the Richards after her first operation can be fully understood by staff only if they are aware of the Richards' financial struggle and understand that Mr. & Mrs. Richards have no other family they can turn to for help.

Mrs. Richards' interview gives evidence of the staff's understanding of the particularities of this family's situation. Mrs. Richards says "nothing seems to help" her mother, yet Mrs. Porter says that the social worker has helped her.

The worker has helped Mrs. Richards sort out her own feelings, describe and understand her husband's role in the situation, understand her feelings of being trapped as an altogether human response to the situation. But the worker has not left Mrs. Richards entrapped; she is working with both Mrs. Porter and Mrs. Richards and with other staff in the institution—the physical therapist, for example—and other agencies such as the department of social services. Thus, accurate and complete information about Mrs. Porter's functional health status, the prognosis for the future, the availability of help from other agencies become a part of the ongoing assessment of the situation for the worker, for Mrs. Porter, and for Mrs. Richards and her husband.

A second important consideration in beginning the work with families requires little explanation for it is a thread of commonality in all of the cases presented. In each situation, the staff treats the family, of which the old person is a

243-962 O - 77 - 3

member, as a unit. The old person is not the client, nor are the other members of the family; the family is the unit of service, and the assessment and helping process benefit if this definition is kept in mind. For example, Mrs. Porter and her family represent a situation where even the most professional social worker can get caught in the trap of sympathy for Mrs. Porter and anger at her daughter and son-in-law for not accepting Mrs. Porter's excessive demands on them.

Third, there is the importance of interdepartmental communication. In a large and well-staffed facility, such as the one in which Mrs. Barth lives, this communication is, of necessity, systematized, characterized by interdepartmental memo's and formal staff conferences. In the small facility, such as Mr. Randolph's, staff assignments are less specialized, the system of communication less formal and more likely to be ad hoc face-to-face conferences.

Whatever the pattern, in each case dissemination of information and agreement on a plan of care are important. Mrs. Barth might not have gone to the family party if there had been bureaucratic confusion and her medications had not been prepared for her by the pharmacy department; or, at the least, an unnecessary obstacle would have made an already difficult situation even harder for her and her family.

Finally, to underscore the central thesis of this manual, from the first contact, every action by staff must serve to articulate the partnership between family and institution. The message is delivered explicitly, but has no meaning unless it is embedded in relationship and activity. With the Anderson's, Barth's, Kaye's, and Mrs. Porter and her daughter, this articulation of partnership is relatively easy, for the institutional and familial definitions are essentially the same. There is no question in any of these families that, although the major responsibility for performance of *uniform* task, for providing Brody's "basic maintenance and medical and paramedical services," is now the institution's, the families know there are responsibilities which are still theirs, unless, in Litwak's terms, the function of care of their aged family member is shared.

Chapter 3. The Family-less

You have already met Miss Farrell who came into the long-term care facility family-less. Miss Farrell did have family, her cousins, listed in her social history. But in her case, a distinction which the sociologists make in their studies of the family was one Miss Farrell also made. The cousins were *relatives*, people to whom she was related by blood and with whom the ritual contact of yearly Christmas card exchange was maintained. But they were not her family; her mother and father and she had been an example of "the isolated nuclear family," about which so much is written.[1]

Her mother and father had created a new family when they married, and the ties which each had had with the families into which they were born had been severed – save for the annual Christmas cards. Miss Farrell had remained single and, except for the few years between her father's death, when she was already in her 60's, and her entry into the institution, she had lived her entire life with her parents.

The social services department records showed that a burial plot next to her mother and father was reserved and paid for, and the allowable funds for her funeral had been set aside at the time of her admission to the long-term care facility. I have already described Miss Farrell, the pattern of her life in the institution, the staff's perception of her, and her own story of her life. I have told you about the facility, that its social services department was as seriously understaffed that social services could be provided only in emergency situations, as with Mrs. Porter, and/or in response to direct requests either from family or patient.

Let us imagine for a moment that Miss Farrell lived in a home like those of Miss Anderson or Mrs. Barth or Mrs. Kaye – with their full staffs, their clear commitment to a partnership with families, their procedures and staff resources which permitted assignment of a social worker to each patient and family.

Let us imagine a case conference on Miss Farrell held several weeks after her admission, attended by the physician, nurse, social worker, activities worker, and staff carrying supervisory and line responsibility for provision of care to Miss Farrell. Give to this staff the detailed medical and social history and information required to develop a comprehensive plan of care for Miss Farrell.

Should the plan include contact between the institution and the two cousins, particularly the one who lives in the Metropolitan New York area? Is there any reason to believe that Miss Farrell's emotional needs might be better met if she could be helped to redefine family to include these two relatives? Might it make a difference if she received gifts, letters, phone calls, visits from her cousins? If she were to need an operation or to transfer to an acute treatment hospital, would her cousin be involved or at least informed of the decision? Would it make a difference to Miss Farrell to know that a blood relative, the child of her beloved father's brother, would attend her funeral and see her buried in the family plot next to her mother and father?

Assume that the answers to the questions posed are in the negative. Or assume that the cousin was contacted and was unwilling or unable to be family to Miss Farrell. Should the plan then provide surrogate family for Miss Farrell? Should a volunteer visit her regularly, shop for her, bring her a box of home-baked cookies or fresh fruit or a bottle of brandy? (Miss Farrell had told me in our interview that she and her parents had always had brandy in the evening after dinner, an amenity that she missed.)

Or were most of these tasks which staff and Miss Farrell could handle? There was a well-stocked commissary at the facility. And I learned from my interviews with patients in the facility that, although not true in Miss Farrell's case, many of them had special, informal relationships with staff, that staff often shopped for patients, brought special food delicacies to

---

[1]See Parsons, Talcott. The social structure of the family. In: Anshen, Ruth N., ed. *The Family: It's Function and Destiny*. New York: Harper & Row, 1949 (revised edition, 1959), pp 241-275. Parsons distinguishes between the words *family* and relative; the word *family* generally is used, Parsons says, to refer to the conjugal unit. The word *relative* identifies anyone who is a "kinsman."

them, remembered their birthdays. (In my years on the staff of a home I had performed these kinds of tasks for residents and patients, including, with the knowledge and approval of the physician, stopping once a month at a liquor store to buy a bottle of Old Grand Dad for one of our residents. He had had a 5 o'clock shot of whiskey every day for as long as he could remember. He was a bachelor and, although he had neices and nephews who maintained contact with him, their visits were irregular, on the spur of the moment. He needed the absolute assurance of the once-a-month replenishment of his liquor supply and didn't like to impose on his family. Hence, the guarantee of this aspect of continuity of care was provided by staff by informal agreement.)

Miss Farrell was able to get to the commissary to do most of her own shopping and she had come in well supplied with clothes, etc. She was also an appealing person, the sort of patient who is likely to elicit the sympathy of staff. In our imaginary case conference, even though I have set it up as occurring soon after her admission, I think it would already have been clear to staff that, if Miss Farrell wanted a special relationship with a staff person, she could reach out and staff would respond.

Should the plan of care for Miss Farrell include the institution's taking responsibility for reaching out to Miss Farrell's relatives? If not, should there be systematic provision of a surrogate family through assignment of a volunteer to her? Or could the informal system of the institution be relied upon to provide primary group relationships for Miss Farrell?

The starting point would have been to talk with Miss Farrell. She was entirely intact mentally; staff could not and need not make a decision for her. Based on our interview and what the staff told me about her, I believe she would have acquiesced. It would have been all right with her, as it was all right with her for me to try to contact the cousin, but it probably would not have made much difference to her one way or the other. If her cousin visited or wrote more often or sent her gifts, she would probably have enjoyed the attention just as she enjoyed the visits from the minister and being interviewed by me.

In the Kansas City studies by Neugarten and her associates which are cited in the bibliography, people like Miss Farrell were described. They were pleasant, affable people who eased their way through life, able to connect with other people, but in a shallow way, not investing much of themselves in relationships and, therefore, feeling no deep sense of loss if relationships were severed. People for them were always replaceable. So, I think, it was for Miss Farrell. It was not that she did not need people around her. She needed the nurses and the aides and the dieticians and the waiters, but, in the language of the sociologist, she needed instrumental, not affective, relationships. She needed people for what they did, not for who they were. For example, according to the staff, if the minister left, she would shift easily to the man who replaced him.

If I were the staff worker in that imaginary case conference and if Miss Farrell had given permission to contact her cousins, I would have tried. And if I were unsuccessful in finding the cousin who lived in the New York area – as I was for the study – I would have written the other cousin in Massachusetts. The letter would have been low key:

> We want you to know that your cousin Elizabeth Farrell is a patient in . . . , [with the address and phone number]. With her permission, I am writing to tell you that she was admitted on . . . and that our doctors believe that she will continue to need the skilled nursing care we provide because . . . .
>
> We know from Miss Farrell that you have not seen each other for many years, but that you do exchange Christmas cards each year. Perhaps you could drop her a note occasionally also. We think she would be pleased to hear from you.
>
> If you have any questions, please feel free to phone or write me. I am Miss Farrell's social worker and can be reached by mail at . . . . My phone extension is . . . .

The important thing about the letter is that it should deliver a message of invitation rather than demand. The relationship between the cousins has never been close; the cousin herself is in her 70's. The staff person cannot honestly say that Miss Farrell asked that this letter be written. Some situations call for more aggressive outreach on the part of the institution, but considering Miss Farrell's life history, the "Perhaps you could" and "We think she would be pleased" seem accurate and appropriate.

I would have included one more arrangement in Miss Farrell's plan of care—the assignment of a carefully selected volunteer "friendly visitor"

who could come perhaps twice a month and send cards or bring small gifts to Miss Farrell on special occasions. Miss Farrell is different from most of the other patients on her unit; she is better educated. There is her skill as a pianist and her love of music; she is a reader, not a knitter or a crocheter. I think she would welcome a friendly visitor who had interests in common and who would come more frequently than the minister.

Note the use of the term "friendly visitor" rather than "surrogate family." Miss Farrell does not seem to need people who, in an emotional sense, become substitute family members. She does not reach out to staff for this kind of relationship; hence, the suggestion of "a friendly visitor"—a volunteer who would do some of the things which family and friends do and to whom Miss Farrell would relate in an instrumental, more than affective, fashion.

Mrs. Long and Mrs. Gross are different, and the responsibility of the institution in their cases is therefore different. Mrs. Long's two sons participated in the application and admissions process when their mother came into the home 7 years before I interviewed her. Her social services record was a thick one, and on its pages was recorded a lifelong family tragedy.

Mrs. Long had always been controlling and demanding in her relationships with her two sons. They were in their 50's when she came into the home; both had been married for many years; both were grandfathers. Mrs. Long always referred to her daughters-in-law as "she" or "they," never by name. The sons were frank with the worker: They were bringing their mother to the home because they and their wives could no longer stand her presence in their homes.

One son said,

> We've tried every way we could. Since Dad died [20 years before her admission to the home] she's refused to live alone. She would stay with me until we couldn't stand it anymore, and then go to my brother's. A few months there; then back to me; then back to him.
>
> We're not young anymore. Our kids are grown; we have a right to some peace and happiness, too, And as long as Mom is with either of us; it's nothing but fights and demands—back and forth. It's no way to live, and this is the way it's got to be.

Mrs. Long brought to the home a lifetime of family pathology and a set of relationships in which the dominant themes were anger, abandonment, guilt, relief.

The worker did not question the decision during the application process. She talked with Mrs. Long about how she felt, and Mrs. Long expressed her rage at her sons—and at her daughter's-in-law whom she blamed for all that had happened. Mrs. Long fought every step of the way into the home, but in the end she came:

> I was a sick woman, and *they* [her daughters-in-law] wouldn't take care of me. If I had had daughters, it would have been different. But sons—you know what they say: "A son's a son until he gets a wife; a daughter's a daughter all her life."

The worker talked to the sons about how important it was that they visit their mother regularly. The worker, learning that Mrs. Long loved to go on shopping expeditions and to eat in restaurants, urged the sons to continue this pattern. The sons *did* help their mother get settled in the home; they were always available to staff when family needed to be involved in discussion about Mrs. Long's health status, a room change, etc.

But the sons visited Mrs. Long with decreasing frequency as the months and years passed, the daughters-in-law never. Occasionally, on Mother's Day or on Mrs. Long's birthday, one or the other son might be accompanied by Mrs. Long's grandchildren, and sometimes there were brief notes or greetings cards from them.

One son had a heart attack; his brother informed the social worker of this and asked that all contacts with the family be with him in order to protect his brother from the stress of the mother-son relationship. Mrs. Long's relationships with people in the home—staff and other residents—were always problematic. Although she was active in the organized program of the home, she had no friends and many enemies. The room changes were usually the result of tension between Mrs. Long and her roommates; it was a relief when finally a single room became available for her.

The social services record grew thicker; she was seen periodically by the psychiatrist, weekly by the social worker. There were memo's from the recreation worker, the physical therapist, the supervisor of the dining room.

From the arts and crafts worker:

> Mrs. Long got into a fight with . . . in arts & crafts today. We talked to her about this, because the other residents are complaining about her behavior. Would you talk to her?

From the night switchboard operator:

> Mrs. Long came to the switchboard last night and asked me to call her son. She had been talking to him on the phone, and he had hung up on her. I told her I couldn't do this, but would let you [the social worker] know what had happened.

After one crisis, there was a resident care conference, attended by staff who had the most direct contact with Mrs. Long and by the psychiatrist.

> It was agreed that the social worker should talk with Mr. Long to see if some members of the family couldn't maintain more regular contact with Mrs. Long. There is one granddaughter who seems to feel some closeness to Mrs. Long and the social worker will ask Mrs. Long's son if she can contact the granddaughter.
>
> It was recognized, however, that the strain in Mrs. Long's family relationships is so great with so much bitterness on all sides—that the family probably will not be able to do much more than they are now. It was also recognized that Mrs. Long has no friends in the home, and that staff find her difficult.
>
> The psychiatrist reviewed Mrs. Long's history and her own judgment that Mrs. Long's capacity even to modify her behavior is very limited. She suggested that a volunteer might be assigned to Mrs. Long to do some of the things for her—like taking her out for rides and to a restaurant—that would give Mrs. Long some pleasure.

Here you see the institution staff doing two things. First, they are trying to help maintain the fragile relationship between Mrs. Long and her family. The son was consulted; the granddaughter agreed to take on some of the responsibilities her parents and uncle and aunt could not, or would not, carry. Her visits were not frequent—once a month or every 6 weeks—but they were regular, and each time she came, she brought her grandmother a gift or combined the visit with a ride or a meal in the nearby restaurant. The son who was well continued his irregular and infrequent visits and also agreed to telephone his mother at a regular time every Sunday morning.

38

Second, among the volunteers in the home was a middle-aged woman who became for Mrs. Long the "good daughter" she had never had. The volunteer lived near the home; she had free time; her mother had died when she was young; and Mrs. Ford (the volunteer) was honest in her recognition that she met important needs of her own in being needed by residents in the home.

Mrs. Ford knew of Mrs. Long's reputation in the home. The volunteer director and Mrs. Ford talked about how other people—Mrs. Long's family, the residents, the staff—experienced Mrs. Long as a difficult, demanding, unpleasant person. Mrs. Ford regarded her assignment as a challenge: She *wasn't* Mrs. Long's daughter. She was not a combatant in the Long family battleground. Like staff, she could understand that the sons and daughters-in-law felt they had to protect themselves and their marriages from Mrs. Long's corrosive, divisive influence. Yet, also like staff, Mrs. Ford could sense underneath Mrs. Long's demanding, controlling behavior, the frightened, depressed, bitter woman who needed help.

The social worker, the director of volunteer service, and Mrs. Ford met first. If Mrs. Long and the Long family accepted the plan, Mrs. Ford would accept the assignment. Next the social worker met with Mrs. Long, and Mrs. Long welcomed the plan, partly because it seemed to her that this was validation of her perception of her "rotten family," but partly also because she did want someone who was *hers* and someone who would make possible more frequent excursions out of the home, meals in restaurants, individual celebration of her birthday and other special occasions.

Next the social worker met with the one son and the granddaughter. There was in the social services folder a summary of that conference:

> We talked about the strains in the family's relationships to Mrs. Long and the current problems being faced because of the one son's health problems. I simply accepted all of this as part of what the reality is; I did not challenge Mr. Long's perception or raise questions about whether work could be done on the feeling level.
>
> I shared with them the staff assessment of Mrs. Long's situation in the home, including the suggestion that the granddaughter be asked to assume more familial responsibility and that Mrs. Ford be assigned to Mrs. Long on a regular basis.

As we had surmised, the granddaughter does feel less anger at Mrs. Long and more sympathy for her situation than do Mrs. Long's children. There are limits to what she can do, however, because of her own family responsibilities. We talked very specifically about what she could do and how often, and her uncle said that we and she should not feel that the total responsibility was being "dumped" on her. He would continue to be the "responsible relative," and he would telephone his mother regularly.

I summarized what each would do and then we discussed the volunteer's role. Mr. Long was not very involved in this discussion; mainly he seemed relieved. He offered to pay the volunteer's expenses: "It's the least I can do," and we arranged for him to contribute money to the volunteer department's Sunshine Fund.

The granddaughter really took the lead here: she wanted to be certain that her efforts and the volunteer's were spread out. "Nothing is going to be enough for Grandma, but at least let's make sure we'll not both be doing the same thing at the same time."

After the social worker, son, and granddaughter met alone, they saw Mrs. Long together. The worker notes only,

> It was a difficult meeting. Mrs. Long played each of us against the other, and both she and her son did some yelling. In her usual fashion, she accepted her granddaughter's new role in a grudging kind of way, but the granddaughter took it, and did remind Mrs. Long that her father was ill. She said she was there because she loved both Mrs. Long and her father and wanted to help both of them. Mrs. Long didn't voice acceptance of what her granddaughter was saying; she didn't thank her or express any pleasure; but she did ask when her granddaughter would be there again and asked her to bring her the special brand of talcum powder that she liked.

Then the social worker, volunteer director, Mrs. Ford, and Mrs. Long met, and a relationship which would last until Mrs. Long's death began. Mrs. Long died a year or so after I completed my study, 4 years after Mrs. Ford became her "good daughter." I cannot tell you that Mrs. Ford's and Mrs. Long's relationship was all beauty and sweetness, or that Mrs. Long mellowed in her feelings toward her family, or they, in their feelings toward her. Mrs. Long continued until the last few months before she died to be the difficult person that she had been since the beginning.

But—and there are three but's: First, Mrs. Long did have times with Mrs. Ford which gave her pleasure. Her granddaughter was right that nothing was enough; yet she would return from a ride or a meal out and, as the switchboard operator described it in a report to the social worker:

> Mrs. Ford brought Mrs. Long back to the home around 9:00 pm. Mrs. Ford kissed Mrs. Long goodby, and Mrs. Long returned the kiss. I asked her, as she passed the switchboard whether she had had fun. She didn't answer the question, but did stop to tell me where they had gone for dinner and what she had had to eat. And she was smiling as she talked.

The second *but:* You may wonder why I have included Mrs. Long in this section on the Family-less. She *did* have a family. But as I read records and talked to old people and to staff in many institutions, and as I thought about my own work experience, I knew there were many Long families. And often as the years passed, the Mrs. Long's did become family-less in the functional sense. With each visit or phone call a battle, with family members beset by their own problems, there were families who gradually abdicated their responsibilities and abandoned their aged member.

This could have happened in Mrs. Long's case. At the point that I introduced the Long's to you, it was beginning to happen. It is not unlikely that if the staff had not done what they did, the contacts between Mrs. Long and her sons would have steadily decreased and the granddaughter would not have become involved. The son would, of course, have continued to be the formally responsible relative, but this would have been a family relationship in form only. Mrs. Gross whom you will meet next illustrates the point.

And the final *but* is the final chapter in Mrs. Long's life. When, several months before Mrs. Long died, it became evident to the medical staff that her death was a matter of time, the social worker telephoned the son to talk with him about the deterioration in Mrs. Long's condition. During the years that Mrs. Long had lived in the home, she had always described herself as "a sick woman" and often "as being near death's door." Now, for the first and last time, this last statement was true, but it was hard for staff, for

Mrs. Ford, and for Mrs. Long's family to realize that, this time, Mrs. Long really was dying.

> When I phoned, Mr. Long was out and I spoke to his wife. She asked why I was calling, and I explained Mrs. Long's condition, as the doctor had told me. Mrs. Long, Jr. listened in silence, and then said that she would tell her husband. "I can't pretend after all that has happened that I love her and can forgive her for what she did to all of us."
>
> I said I could understand how Mrs. Long felt. I knew the family should know what the doctors thought, I said, and then I added that I didn't know for sure how Mrs. Long, Sr. was feeling. She was sleeping much of the time now. But it might make it better for the family in the years to come if all of them could visit Mrs. Long before she died.
>
> Mrs. Long said she knew her husband and his brother would come: "It'll be easier for them if my sister-in-law and I and the children come too. We'll talk about it, and one of us will get back to you."

The family *did* come—several times in the weeks that followed. Mrs. Ford came almost daily. The nursing department and social services records include notations of the visits, but no deathbed reconciliations—or recriminations. One afternoon shift nursing report included:

> Mrs. Long's family visited. Mrs. Long seemed in a better frame of mind after they left.

There was reconciliation—no miraculous healing of old wounds—but Mrs. Long did not die alone, unattended. And the family were helped to do what was right, within the limits of their own unique family history.

Mrs. Gross's case record tells a similar—yet different—story. She had come into the home almost 20 years before she became part of my study. There was little in the records of the institution which could shed light on Mrs. Gross's family history.

She had married a widower with two children, age 8 and 10. She had raised the children, been widowed, lived alone, and then came to the home. It was long before the abolition of filial responsibility and most of the early material in the folder had to do with finances—the incomes of the children, the amount they were legally responsible to pay toward Mrs. Gross's maintenance, dunning letters from the institution when they did not make the monthly payments.

I talked with a social worker who had been on the staff for many years and who knew Mrs. Gross well. She remembered the step children only vaguely; it had been years, she thought, since there had been any contact between them and the institution. She could not recall any efforts on the part of staff to reach out to Mrs. Gross's family, nor was there evidence in the records of such efforts.

The worker knew that Mrs. Gross grieved for the children whom she had raised, but who had long ago abandoned her. But somewhere along the line, there must have been a decision. For the last 10 years, Mrs. Gross had always had several volunteers assigned to her. One, in particular, had become a surrogate daughter who visited weekly.

Mrs. Gross was not at all like Mrs. Long: she created no problems for staff; she was an appealing person; and she had friends among the other residents and among the staff. The worker said to me,

> I guess Mrs. . . . [the volunteer] and I are really Mrs. Gross' family. We do all her shopping for her and celebrate her birthday with her and things like that. I know she wishes the children would call or come, but I think she's given up hope that that will happen. She's one who really has made the home her home and us her family.

Mrs. Gross had lived in the same room in the home for the last 7 years. She was failing, but gradually, so that there had been no decisions—a room change, the need for an operation—which might have necessitated a staff attempt to reach her family. Her burial plot, next to her husband's, had been paid for long ago and the money set aside for her funeral.

What would happen if Mrs. Gross became seriously ill? Whom would the home call if she died suddenly one day? "The stepchildren, of course," the worker said, "although I don't even know whether these addresses and phone numbers are correct."

I interviewed Mrs. Gross and found her exactly as the social worker had described. She had come to the home so many years ago that it was hard for her to remember exactly what had happened or how the decision was made. She did remember that she had become lonely when neighbors whom she had known for years were moving away or dying. One of her neighbors had come into this home to live and Mrs.

Gross had visited her and decided that this was the best place for her.

She remembered telling her stepchildren of her decision and that they agreed and helped her make all the arrangements. She couldn't remember the last time she had heard from them:

> They're not my own blood, you know, and before the law was changed [the abolition of filial responsibility] they used to get mad because the home kept wanting more and more money. I thought maybe after the new law, they'd feel different and come oftener. But they didn't.

Could the home have done anything? I asked Mrs. Gross. What if the social worker had called them and told them Mrs. Gross wanted to hear from them? Mrs. Gross shrugged:

> Maybe, maybe not. They didn't hate me; we didn't fight. They've got their own lives to live. It's no use talking about it now. What I need, they give me here, and I've got . . . and then Mrs. Gross named the social worker, the volunteer, a member of the housekeeping staff and two other residents.

When I asked for permission to contact her stepchildren to interview them, she refused. Like the social worker, she wasn't sure that she or the home had the right addresses and phone numbers. But more than that, she said, "They might get angry. It's better to leave it the way it is."

I, of course, didn't contact Mrs. Gross's stepchildren; I did check the phone book, though. One was listed; the other was not. When Mrs. Gross does become seriously ill or dies, the home will probably be able to notify at least one member of her family.

Like Mrs. Gross, I don't know what would have happened if the staff had reached out to her stepchildren as they did to Mrs. Long's family. Mrs. Gross is right, they're not "blood relatives," but she *was* their father's wife for 30 years and she *did* raise them.

I think about them: Would they feel better if the home had helped them maintain contact with Mrs. Gross? Would they have set a different kind of example to their own children if they had done so?

I think about Mrs. Gross: She is not alone. She did, as the worker said, make the home her home. Her roommate, whom she listed among those she has, she described as "closer than a sister could be" and the volunteer and the social worker are "like my own daughters."

So Mrs. Gross has a surrogate family—not like Miss Farrell who didn't really need family—not like Mrs. Long where the volunteer supplemented the family. Mrs. Gross will not face death alone, nor will she go unmourned and forgotten. She acquired her surrogate family, as many old people in long-term care facilities do, partly through the informal system of relationships which develop among residents and between residents and staff. Her volunteer daughter was assigned to her in a formal way: The staff knew that she was family-less in the functional sense, that she needed affective ties and someone to "do for her."

Yet if we could turn the clock back, I would wish for a case conference which would have included the recommendation that with Mrs. Gross's permission, her stepchildren be contacted by staff. If I were the worker, I would, as in the case of Miss Farrell, make the contact low-key. These were not "blood relatives," as Mrs. Gross said, and it may have been that they felt they had discharged their responsibilities to their stepmother by helping her get into the home, and contributing to her maintenance during the years of their legal responsibility.

Mrs. Gross was not an assertive woman. I wondered if anyone had ever told her stepchildren how important they were to her. It's not enough to say, "They should have known without being told;" maybe they didn't know. Or as Mrs. Gross said, "They had their own lives to live," and the social worker remembered that both were struggling to make ends meet. The neighborhood in which one of them lives is a declining area in the city; maybe their lives have not been easy and their financial and emotional resources have been limited. Perhaps they feared the demands that might be made on them and certainly those early years of dunning letters could not have made them feel good about the home.

All of this is speculation. The only reality is the home's failing to reach out to Mrs. Gross's stepchildren to give them a chance to be partners and help in assuming even a limited partnership. If we compare Mrs. Gross's situation with that of Mrs. Long or Mr. Randolph, it is at least possible to say that it would have been worth a try.

Chapter 4. The Staff: Assignment, Communication, and Training

The cases presented have, by implication at least, illustrated certain points about staff which now need to be discussed more systematically. First, I believe that the social services which long-term care facilities are mandated to provide —*including work with families*—are best provided by qualified, credentialed social workers.

Second, as noted in the discussion of Mr. Randolph, the size and complexity of the facility as an organization act as important variables in determining the nature of staff work assignments and the extent to which interstaff communication patterns must be formalized in a systematic kind of way. In most instances, the best guarantee that a job will be done and that staff can be held responsible for doing the work they are supposed to is provided if staff assignments are clear and specific.

Although all staff must, by their behavior, articulate the partnership between the facility and the family, work with families must be a specific assignment to certain staff—my preference is the social worker—and they must be accountable for this part of their total workload. Therefore, they are also responsible for working with other staff who come in contact with families and for inservice training of staff.

As we saw in the cases presented and as you know in your own work, other staff, by virtue of where they are, when they work, and what they do are in frequent contact with families. Their orientation to and training for their work in your facility must include discussion of both the philosophy of the facility—the family as partner—and how to work with families.

There must be patterns of interstaff communication to guarantee a continual flow of the information that staff need in order to work with individual family members and the old people in an informed, sensitive, and skillful way. The case of Mrs. Long, for example, illustrates the importance of the switchboard operators. Their physical location in the facility, usually near the entrance or the main entrance, means that they are witness to many family encounters that other staff are not. Moreover, their hours—they are on duty in the evenings, at night, over the weekends, on holidays—similarly place them in a unique position. They are there during peak visiting hours; they know about evening and night phone calls; they see residents and patients returning to the facility from visits to their families.

Often their job assignment includes sorting of the mail each day, and, even in a large institution, the mail sorter and distributor may know about important patterns of communication between the old person and her family. I remember from my own work experience one fierce old lady—not unlike Mrs. Long. Like the Long children, her son and daughter had fled from their mother's sharp tongue and efforts to manage their lives.

But Mrs. Schwartz, my fierce old lady, was different from Mrs. Long, since she never voiced anger at her children's neglect of her. Sometimes, though rarely, she wept because she was lonely for them, and always she defended them. They didn't come because they were working hard; one was ill; the other's wife wasn't well. There was always a reason which preserved her public image as a devoted mother of loving children.

One day the switchboard operator who sorted the mail and I were talking about Mrs. Schwartz. It was not, I confess, the professional information sharing or staff training conference I have recommended; it was instead the kind of casual coffeebreak conversation that is familiar to all of you.

Mrs. Schwartz's name came up and the switchboard operator told me that every other Monday Mrs. Schwartz waits while she sorts the mail because her grandson away at college writes regularly every 2 weeks. "It's a shame Mrs. Schwartz can't write him," the switchboard operator said; then other people joined us and the casual conversation was over.

Mrs. Schwartz couldn't write her grandson; she was foreign born and had never achieved much facility in written English. And now her fingers were arthritic, making writing in any language difficult. In the year or so that I had known Mrs. Schwartz, we had never talked about her grandson. I look back now and realize I was then still inexperienced in my work with

old people in long-term care facilities and unaware of the importance of family members other than the most obvious ones—in Mrs. Schwartz's case, her children—and also not fully aware of the importance of other staff.

"You never asked me about him," Mrs. Schwartz pointed out, when I asked about her grandson, thus teaching me the importance of information about the entire family of the old person. She told me then about how she used to take care of Billy when he was little, of the weekends he spent at her apartment and the excursions they used to take around the city. Here was the one relative who loved Mrs. Schwartz in an unambiguous way. Like Mrs. Long's granddaughter, Billy was one step removed from the battle between his parents and his grandmother, and his memories of her were sweet ones. Mrs. Schwartz showed me the packet of letters from him; they were short notes for the most part.

> I'm fine—working hard—got an A on my mid-term last week. I hope you're well. I'll see you when I come home for Thanksgiving.
>
> Love, Billy

This was a typical letter, but Mrs. Schwartz wanted me to read each one aloud to her, and I still remember that afternoon as one of the happiest events in my professional career.

Mrs. Schwartz's eyes were not good, and Billy's writing was not always neat and clear. She told me that one of the aides read the letters to her when they came, and then Mrs. Schwartz would spend time rereading them to herself. Would she like to dictate answers to Billy's letters to me, and we would mail them?

Each week after that Mrs. Schwartz came to my office, she dictated her letters to me, signed them herself, and then she would stay to make sure that the envelope was addressed, stamped, and placed in the mailbox. Once I added a note to Billy. Since he was only 19 or 20, I thought he should know that we at the home respected his fidelity to his grandmother. Several times Mrs. Schwartz included dollar bills in her letters—carefully saved from her personal allowance money, "so you can buy yourself something."

Years later when I was interviewing old people for my study, one of the questions was: "Do you write or phone your relatives?" Often the answer was: "I used to, but I can't anymore."

Failing eyesight, impaired hearing, arthritic fingers—these were the usual reasons why the old people could not, on their own, maintain their side of the phone and letter contacts with families.

In telling the story of Mrs. Schwartz, I have strayed from the main theme of this section of the manual. But her situation illustrates the importance of *all* staff of the facility helping old people and their families maintain their relationships to each other. The switchboard operator and the aide who read the letters to Mrs. Schwartz are among those naturally intuitive, willing-to-help people which every facility seems blessed with. They needed no instaff training to know that Billy's letters were important to Mrs. Schwartz. *But* inclusion of content about family relationships in staff training might have alerted them to the importance of communicating to other staff—the nurse, the social worker—what they knew. Then our ability to help Mrs. Schwartz maintain her end of the correspondence would not have been so long in coming nor the result of an entirely happenstance conversation.

Training and a built-in system of interstaff communication were the necessary ingredients missing in this situation. I have included a protocol for interstaff memo's in the final section of the manual. It may not be needed in all facilities; in a small one, a note or phone call or face-to-face conversation may be quite sufficient. In other facilities, the patient-care conferences may include staff like switchboard operators, housekeeping staff, aides, etc.

In one skilled nursing home I know, the social worker, in preparation for the conference, checks in before the meeting with other staff who have contact with the patient and the family, but who are not included in the conference. I watched her work one day. She talked to the switchboard operator, the dining room waiter, the housekeeper in the unit, and all three shifts of aides.

Her questions, not limited to family relationships, were designed to get as full a picture as possible of the patient's life in the facility. But included were questions about the family—visits, phone calls. Who came? Was the patient satisfied? Did the family seem satisfied?

She had come to include these kinds of questions in her preparation for the case conference through an experience not unlike mine. One of her patients had no family except a son in up-

state New York who wrote regularly every week and visited twice a year. One day the switchboard operator who sorted the mail mentioned to the social worker that it had been several weeks since the patient had gotten a letter from the son. The social worker talked with the patient who was bed bound. It had been several weeks and the patient was worried. She had talked about her worry to the night aide to whom she felt close, and the aide had tried to reassure her but had not told the nurse about the conversation.

Would the patient like the social worker to call the son? Oh, yes. So the worker did. The son had had a heart attack; the daughter-in-law, beset by the strain and worry, had given only a passing thought to her mother-in-law. She had planned to contact the staff when her husband was out of the woods. In the meantime she thought it better not to worry her mother-in-law with the bad news. The worker explained that the patient was already worried because her son hadn't written, and she got permission from the daughter-in-law to tell the mother what had happened.

The get-well cards were purchased and sent regularly by the mother—with staff help—during the son's recuperation period. In the process, the worker saw the packet of letters from the son, all on his office stationery, and the worker's hunch was that the wife probably didn't know that the son wrote weekly to his mother and didn't really realize how quickly the mother would become worried.

As in my experience with Mrs. Schwartz, the worker had learned a lesson, hence her inclusion of other staff and questions about family relationships in her preparation for patient care conferences.

These have been somewhat dramatic illustrations of the importance of staff training and interstaff communication. In my study, the interviews with families included a series of questions which were designed to tap information about which staff the family knew, how they knew them, and whether they were satisfied with the way *they* were treated by the staff.

In many cases in facilities where, in fact, there was a social worker assigned to each old person *and her family*, the family did not know the worker's name or whom they could contact if they were dissatisfied or had questions about the care provided their relative. In such facilities, it seems to me that a letter to the family could be sent at the time of admission and could include the name of the social worker and her extension. In one facility, the workers have cards, like business cards, with the worker's name, office number, and hours, which are given to relatives.

In another large facility the administrator makes regular rounds on Saturdays and Sundays, visiting with *both* patients and families. The social services and nursing directors told me that every Monday morning both of them receive a large number of notes from the administrator, asking for followup on questions or complaints from families. In another smaller facility, where Mr. Randolph lives, the administrator and social worker/activities worker are on duty on Sundays, using this time to see families.

Not unexpectedly, because of the time they visited, many families know by name the evening shift aide who took care of their relative. Because this was the person they knew best and they knew was directly and regularly involved in the care of their relative, they often took their questions—and complaints—to her. This finding again illustrates the importance of training for all staff. *Believing that work with families is part of the core task assignment of the social worker, I argue for the presence of social workers in the facility in the evenings and over the weekends when families are most likely to be visiting.*

Third, the satisfaction/dissatisfaction which families expressed with their treatment by staff was, sadly for me, often a function of *small* things—sins of commission and sins of omission. In the end I came to believe that most of these small things about which families complained need not have been. As we analyzed the complaints, we could categorize them:

1. Some had to do with policies, procedures, and facilities which I'll talk about in the next chapter.
2. Some had to do with staff behavior: Families complained about staff who were at the least not helpful to them and at the most were rude to them or, as one daughter put it, "unfeeling and callous."
3. Some seemed caused by the absence of work with families as a specific staff assignment and poor interstaff and staff-to-family communication.

The policies, procedures, and facilities discussion comes later. Let me now cite some of the behavior that made families feel that they

were poorly treated by staff. You remember Mr. Barth's feeling that the social worker thought he and his brother *should* feel guilty.

Granted that there are families like the Gross stepchildren who do, in fact, abandon their relatives. Yet in my study, 85 percent of the old people who had families were visited by them at least once a month; 65 percent were visited twice monthly; and 50 percent had visitors once a week or more. Moreover, many of these families did other things:

- 49 percent of them telephoned their aged relatives
- 69 percent brought special food treats
- 62 percent provided small necessities, Mrs. Long's favorite brand of talcum powder, for example
- 40 percent took their aged relatives home for visits or for special family gatherings, as in Mrs. Barth's case.

There are more statistics, but these are illustrative and similar to those cited in other studies.

Moreover, the conclusion reached by Gottesman and Hutchinson in their analysis of the "Characteristics of the Institutionalized Aged" was similarly borne out in my study.

> There are two major reasons why people are in institutions. First, they are likely to be suffering from one or more disabling chronic condition. Second, they are likely to lack the psychological, social and/or economic means for dealing with their condition outside an institution.

Ninety-seven percent of the people in my study had had a serious illness, accident, and/or operation within a year prior to admission to the home, and the majority of both the old people and their families cited poor health as the primary reason for entry into the institution.

The studies which Gottesman and Hutchinson cited as evidence in support of their conclusion and the analysis of the functional health status of people in my study are evidence that the institution with its capacity to provide daily medical and nursing care and assistance with the activities of living is an arrangement of choice—as Mr. Barth said, he and his brother didn't and need not have *felt guilty* about the fact that they could not care for Mrs. Barth in her apartment.

Second, I am arguing that the majority of families, through their visits, phone calls, letters, gifts, etc., continue to carry their share of the responsibility for caring for their aged member.

Yet, many relatives in our interviews said things like:

> The staff just doesn't seem to believe that I really love my mother. Every time I come [and this daughter visited once a week and talked to her mother every other day on the phone] I have to prepare myself for . . . (and she named two staff) saying something about how much my mother misses me.
>
> . . . .
>
> I don't know what it is. I just don't feel completely comfortable when I come. . . . [the administrator] knows my situation [this was a 65-year-old widow, taking care of her ill daughter's family and visiting her 87-year-old mother weekly], and she understands. But some of the other staff: a few weeks ago I didn't have time to shop for mother and . . . [one of the staff] said something about how much my mother had wanted the things I was supposed to pick up. Maybe I shouldn't have reacted the way I did; maybe she didn't mean it the way it sounded. But I felt bad enough as it was. I'd like to visit more and do more. But Mom understands. I went home that day and cried—but partly I was mad. I shouldn't have to explain to . . . [the staff member] the load I'm carrying right now.
>
> . . . .
>
> Sometimes I feel as if some of the staff resent it when I come at meal time and feed my Dad. I try not to get in their way or bother them too much. But like last week: Dad had been asking and asking if he couldn't have applesauce once in a while. The nurse said the doctor said it was okay. So when they brought his tray, I asked if they could get some applesauce for him, and the aide blew her stack at me. I didn't complain to the nurse. Dad said not to—that it would just make trouble for him. So the next time, I brought so[illegible]mall jars of applesauce for him—but ther[illegible]no place except the window sill to put th[illegible]n. And I heard the maid complaining that this is why they can't get rid of the roaches.
>
> . . . .
>
> From a granddaughter whose mother had died just weeks before I interviewed her and who now was visiting every week as her mother had done. I don't have anyone to leave my little girl with [age 2½]. They won't let her up on the floor, so I have to leave her in the lobby while I go up to get my grandmother. I asked the guard to watch her. Grandmother always knows when I'm coming and she's ready to be wheeled down. The guard told me this wasn't his job. I asked the aide whether

she could bring Grandmother down for me, but she said she can't leave the floor. Finally, I asked one of the other families who were visiting to watch my daughter while I went up. I guess this is what I'll have to do. I asked if she had talked to her grandmother's social worker about this. No that hadn't occurred to me. Could she help?

. . . . .

Mom and I always talked by phone every evening around 5:30 p.m. when I get home from work. I asked the aide whether she could wheel Mom to the wall phone in the hall at 5:30 every evening. She said this was when meals were being served and everyone was too busy and besides Mom is in the dining room then. We tried to work out another time; I even offered the aide money. Sometimes Mom can get to the phone when I call, but a lot of times one of the other patients answers and just hangs up or an aide answers and says Mom is already in bed and she can't get her up again.

These were typical kinds of situations in which the behavior of staff made families feel that they were being blamed for not doing enough for their relatives, or that in their attempts to do so, they were making extra work for staff or interferring with the institution schedule.

If you analyze each situation, something could have been done to help. Staff training—the articulation of the partnership—would have made a difference. Staff members can be helped to understand that the visits, phone calls, special food treats, feeding are all ways that families have to continue to express love and/or a sense of responsibility to their relatives.

In staff training sessions and conferences, the mixed feelings—guilt, sorrow, anger—that characterize all human relationships can be discussed. Not all daughters feel discomfort when staff tells them how much their mother misses them; staff can talk about why a daughter feels this way and can learn how to help the daughter feel welcome in the institution. The administrator and the mother understood another daughter's family situation; somehow that understanding was not communicated to other staff. The daughter, who was carrying an already heavy load of worry, work, and grief, went home with the additional burden of feeling misunderstood by staff, and with rage at them for not understanding the situation.

The granddaughter who had no one to leave her child with, and her grandmother, and the daughter who could not set up a regular phone schedule with her mother, and her mother, were four people victimized by what I call "sins of omission." It would not have been too difficult in either of these two institutions to make the arrangements for the families to maintain their accustomed patterns of contact. A staff sensitized to the importance of these contacts, committed to a philosophy of partnership with families, and made aware, through interstaff communication, of the particularities of these two situations could have done what was needed.

Included in the Appendix to this manual are suggestions for instaff training content about families and their roles in provision of care. There are also suggestions for additions to or modifications of certain forms in the Brody Manual so that they include more detailed information about families which can routinize the interstaff communication so essential for all staff in contact with families.

Chapter 5. Policies, Provisions, and Facilities: Obstacle Courses or Facilitators

Visiting Policies and Provisions

Let's start with the obvious—the matter of visiting policies among long-term care facilities. There is so much variation in these policies that it's difficult to believe they are altogether rational. One institution with both skilled nursing units and a health-related facility announces in its handbook for families:

> Visitors, including Children, are Welcome at all Times.

Another facility limits visiting hours from 11:00 a.m. to 7:00 p.m. and prohibits the presence of children under the age of 12.

Still another one limits visiting hours in the same fashion, but permits children of all ages to visit—except on the skilled nursing floors themselves.

Another facility limits the number of visitors a patient may have in her room at any given time.

In many facilities, the limitations on hours, the age of visitors, and the number are not enforced when the patient is placed on the critical list.

Over and over again when families and old people were interviewed, policies which made visiting difficult were cited as problems or sources of dissatisfaction. More positively, in those institutions where visitors, including children, were welcome at all times, there was evidence that this open-door policy made important differences to families and their aged relatives.

For example, families in the institutions where the handbook, signs, letters to the families, and conferences with staff all included the statement of the open door often cited this statement as important in making them feel welcome in the institution. One nephew, who lived near the home and visited his uncle almost every day on his way to work, talked about this.

> I can usually drop by almost every week day. I get here around 8 in the morning—sometimes it's just for five or ten minutes and I bring him the morning paper. Sometimes I can stay longer. He was like a father to me when I was a kid—and now I can repay him for everything he did for me.
>
> The truth is I like it, too. Uncle Dave is sharp and there are times I talk over with him some of the problems I've got. He listens—sometimes he's got good ideas—sometimes just his listening helps.
>
> *If the home didn't let me come early in the morning, I couldn't see him as often. I'm tired after a day's work and usually I just want to get home then.* [emphasis added]

Another family:

> I remember when we read the Handbook before Mom came in. It was such a comfort to her. She had thought it would be like a hospital and she'd never get to see her great grandchildren who are all little.
>
> We don't bring them often—on Christmas and Easter and her birthday and times like that. But it was just knowing that they *could* come that helped.
>
> Also the fact that we can come anytime helps. We all work and Saturdays we seem to spend most of our time cleaning and doing things around the house and running errands. A lot of Sundays we spend at our kids' houses or they come to us.
>
> So a lot of times we'll run over for a while of an evening during the week. Or on Sunday my husband and I often come early and go to Mass with mother at the home, and then we'll be back in time for our kids.

A son whose mother is in an Orthodox Jewish Home:

> I know the policy is that families aren't supposed to come on Saturdays. But it's the only day that I can come and spend any real time with her.
>
> I'm not young myself [he was 62] and I'm tired at the end of the day during the week. Sundays there are our kids, and my wife's family. Sometimes we all come on Sundays, but the best day for me is Saturday.
>
> I appreciate that they [the staff] understand. I see lots of families here on Saturdays—not as many as on Sunday, but still a lot. If they enforced the rule, I bet there would be a lot of people like me who couldn't visit as

often or stay as long. It wouldn't be good for women like my mother who live for our visits.

Or think of Mrs. Porter whose daughter brought her children—even though there is a large sign at the entrance to the building:

> Children under 12 are prohibited from visiting.

Mrs. Richards brings her under-12 children with her when she visits.

Or the granddaughter whose visits are made difficult by the rule prohibiting the presence of children on the nursing units and by the lack of provision for care of her child while she goes up to get her grandmother.

The handbook of another facility is 18 pages long and presents the services of the facility and its rules and regulations in detail. The words *family* or *relatives* appear nowhere in the booklet; the word *visitor* appears first in a sentence which contains prohibitions on visiting.

> "It was strange reading the Handbook," one daughter told me. "We got it before Dad came here. It chilled us sort of; I can't quite explain it, but I remember Dad commenting on how impersonal and institutional it seemed. And we all worried about whether we were going to be able to visit Dad regularly and whether we'd feel comfortable when we were there.
>
> "Then we talked to the social worker. She gave us such a different picture and it's been more like she said than the way it was in the handbook. Maybe when you finish your study, you should tell them they ought to rewrite that handbook.
>
> "And I still think the rule against children on the units ought to be reconsidered. Is it really necessary?"

There are two things to be emphasized here: First, the handbook—in contrast to those of many other facilities—was written in formal institutional language. The reaction of the daughter and her father when they read it seemed understandable. The visiting policies as presented in the handbook were among the strictest I had seen even though, as the daughter discovered, they were not enforced. The absence of the words *family* or *relatives* may seem a minor point, yet *families* and *friends* might have conveyed a somewhat different message than the word *visitors* did.

Is the policy prohibiting children on the units really necessary? As I watched children visiting in other facilities, I came to believe that this policy should be carefully considered. It certainly makes it easier for staff not to have children on the skilled nursing units. In multi-occupancy rooms, respect for the emotional and health status and privacy of the roommate may make limitations necessary. In facilities for visiting, lounge areas on each floor are an important provision. All of the policies and procedures of the facility should be periodically reviewed with the daughter's question in mind: Is the policy *necessary* or is it there for the convenience of the staff and the smooth operation of the institution?

The staffs of the institutions with open-door policies report no unsolvable problems arising from these policies. There were times when the need of one roommate led staff to ask that visitors to the other be limited or that the visits take place in lounge areas. There were times, for example, at the height of an epidemic of colds and flu, when families were asked not to take children on the skilled nursing units. And there were times when children got out of hand and staff had to send them back to their parents or suggest "a little quieter, please." But, to repeat, none of these problems was experienced by staff as unsolvable, and the pay-off to the old people made the extra effort worthwhile.

The same principle held for other policies. I've talked before about the importance to the old person and their families of other familial activities—bringing of food treats, small necessities, phone calls, visits outside the institution. Institutional policies, procedures, and provisions (refrigerator space for patients' private food treats; private possessions; locked storage space, etc.) can seem to facilitate or impede family activities in these areas just as they do in the matter of family visiting.

In my study, I found that the most typical family activity, second only to visiting, was that of bringing food treats to their aged relatives. In my analysis of this finding, I wrote:

> First, it was rare that the treat was the anonymous box of chocolates or can of hard candy which is the stock of most gift shops in hospitals and long-term care facilities. . . . Instead, most families brought food which the old person particularly liked, and which was either never or too infrequently on the menu of the institution.
>
> The term "institution food" is a popularly used one: It describes food, which may, in fact, be well prepared, using quality ingredi-

ents, but which is *institutional* because it is prepared for a large group; because rarely can idiosyncratic preferences be fully attended; and because it is the day-in-day-out menu for the institution. Whether it is the privileged school-age youngster at the sleep-away camp, the young adult on the dormitory food plan at college, or in the armed forces, or the old person in or staff member of an institution, complaints about the food are endemic. And the plea of the youngster, the young adult, or the old person to their family is "Send Food."

In the gerontological literature there are references to "regression" among the aged and the consequent need to provide "oral gratification." Administrators of all total institutions and of short-term, acute treatment hospitals are alike in their characterization of "food" as one of the most "niggling" and never-ending problems they face.

Formal organizations clearly vary in their ability to cater to idiosyncratic preferences; at the most concrete level, budgetary considerations may act as constraints with respect to the quality of the ingredients, the number and expertise of dietary staff available for preparation of meals which include choices, the availability of staff to ascertain the choices of individuals and to communicate this information in a systematic fashion to the dietary department. In hospitals and long-term care facilities, there is the added dimension of the medically prescribed "special diet:" that is, the blandness and the limited range of many of the diets prescribed for the institutionalized aged. If the prescription is rigidly enforced, the old person may automatically be denied both variety and many of the dishes she enjoyed the most. The salt-free diet, for example, is a particularly onerous one for the individual—of any age—who enjoys highly flavored and spiced foods. And for the old person whose taste buds require special stimulation, all foods can become bland and tasteless.

In the process of data collection, there seemed at first a bewildering array of special food treats, but as we moved from institution to institution, a pattern began to emerge. And when finally all the data were collected and inter-institutional differences could be examined, it became possible to order the infinite variety in an empirically and theoretically sound fashion. . . .

The first element of the pattern was a cultural and ethnic one. For the Jewish subjects in all these institutions where they were to be found, the food treats were, almost without exception, the delicacies of Jewish families, prepared in a special regional fashion. Jewish, Italian, and Irish families often brought wine or whiskey also; this was rarely reported among Protestant families, and in only two instances in which the subject was both Protestant and female. In both of these, sherry was the treat. Italian families characteristically brought, in addition to wine, special pastries and fruit, so that the bowl of fruit and tins of pastries in the room came for us to be the sign that at least one occupant of the room was Italian.

In the institution which has the most heterogeneous patient population, there was the daughter of a man from the British West Indies who brought and ate with her father a full course meal, featuring an ethnic fish dish which was the delicacy he most craved. And there also was the son of a black man, born and raised in the rural South, whose response to the question was "Soul Food, cooked with tender, loving care."

The last phrase, "cooked with tender, loving care" describes the second element in the pattern of the food treats. With the obvious exception of the fruits and whiskey, most of the treats were home-made, not purchased. This is in part a function of the ethnic and cultural character of the treats, but not entirely. Relatives talked about family recipies—about a particular way their family had always prepared a dish; it was this quality that the old person wanted. One daughter said of her institution-bound mother, "She wants a home-cooked meal once in a while." A wife who visited her husband daily, brought a home-cooked meal with her each day, and fed him this for his noon meal. "He wouldn't eat anything if I didn't do this."

A third element in the pattern reflects the family's attempts to attend a somewhat different order of idiosyncracies of their aged relative—these having to do with lifetime routines of daily living. There were those who were early risers and "always had to have his cup of coffee (or juice or tea) the minute he got up." There were others who always had had a piece of fruit as a late evening snack. There was considerable evidence of the institutions' attempts to meet these idiosyncratic schedules. Sometimes they were systematic: an 8:00 p.m., serving of fruit juice and cookies, for example. Sometimes the attention was in the informal system of the institution: One early riser had a 5:00 a.m. cup of coffee provided by the nursing staff from the coffeemaker in the nursing office or the unit. (There was, it should also be noted, considerable evi-

dence of staff in the informal system acting as surrogate families in the bringing in of special food treats—not just in attending to idiosyncratic schedules.)

In essence, the provision by families of a small electric pot to boil water, a can of coffee or tea, small cans of fruit juice, a supply of fruit, a tin of pastries frequently was a manifestation of the family's attempts not only to cater to idiosyncratic food preferences, but also to enable the old person to maintain at least a semblance of what had been her accustomed daily routine. . . . Yet it is clear that performance of these tasks also serves in many instances to maintain and articulate the effective ties between the old person and the family. . . .

Every family activity could be described in this fashion. The important point is that institutional policies, procedures, provisions, and staff attitudes affect the ability of the family to share in the care of their aged members. And second, families and the aged residents feel better if family activities are encouraged by institution and staff.

Facilities

Here we are talking about parking areas, lounges and their location, coffee shops, etc. Of course, many long-term care facilities located in built up sections of the city cannot provide parking areas for visitors. There are, however, other institutions—in my study three of the five —which are located in less developed areas of big cities or on the outskirts of towns where land values are not prohibitive and space is available. Here visitors' parking areas can be provided by the institution. As I drove to institutions, the five in the study and others which I visited, signs which said things like *visitors' parking area* seemed to deliver a message of welcome. And families commented on the ease, or difficulty, of transportation as something which could affect their visiting pattern.

One institution located in a built-up city area had allocated substantial space for staff parking. Most of the parking spots were, of course, occupied during week days, but after 5:00 p.m. and on the weekends, there were usually many vacant spaces. One son, a paraplegic who drove a specially equipped car and had license plates identifying the driver as disabled, visited every Sunday. He often had trouble finding parking on the crowded streets around the institution, and several times, after circling fruitlessly, he returned home without visiting his mother. He noticed the empty spaces week after week in the staff parking area and requested—first verbally and then in writing—permission to park his car, citing his physical disability which made walking long distances impossible. His request was not granted on the basis that permission for him would create problems!

I think again of the question: Is this policy necessary? It seemed to me that a better resolution would not have been difficult. It would not have been hard to get a count on staff parking on evening and weekend shifts in order to reserve the necessary number of spaces and to open the remaining parking area to visitors on a first-come, first-served basis. The policy would require explanation; even one of the security staff might have to be assigned to the parking area. These seemed small prices to pay for the convenience afforded to families and for the welcome message such action would have delivered.

And the son's need was unusual, his handicap, visible and unmistakable. The justification of the refusal on the grounds that giving him this privilege would set a precedent seems to me untenable. If families are to carry their part of the responsibility, the institution must help. In this case not only was the help not forthcoming, but the son's bitter conclusion was that the institution was inhuman, in the staff's apparent lack of sympathy for his situation, in their apparent lack of concern about his mother and her need for regular visits from him.

The old buildings in the institution in which I worked, like many such facilities, had few lounges, and on many units there was literally no place for visiting except in the residents' and patients' rooms. We were constantly aware of the problems this lack of amenities created for our residents, families, and staff. In the health related facility buildings, the absence of lounge areas on each unit was an inconvenience, but the relatively mobile residents in these buildings could and did use the lobby area, the main lounge, the dining room, the library, and other such rooms for visits.

For the room- or floor-bound patients on skilled nursing units, the lack was much more serious. Like those in many other facilities our nurses were creative in making maximum use of available space. It took extra staff time and effort, but the unit dining and occupational

therapy rooms were set up for visiting at peak times. Even the nurses' office was commandeered sometimes when the need of a family for privacy was particularly acute and the patient could not leave the unit.

I remember with particular respect one night nurse. When a patient was critically ill and the family was there during the night, this nurse always came up with pots of coffee or tea, snacks, comfortable chairs—even though none of these amenities was officially provided.

I cite these early experiences as reminders that, when staff has real regard for the role families play in the lives of the institutionalized aged, even if proper facilities like lounges and waiting rooms are not there, ways can be found to help make families comfortable and insure at least some privacy. In many facilities—and in most of those of recent construction—there are lounge areas and coffee shops where relatives and friends may visit with the old person. Such areas serve a symbolic, as well as real, purpose. They underscore the open-door policy of the institution, help make visitors feel truly welcome, protect the roommate from feeling pushed out of her own room by the presence of the other's relatives.

For the institution-bound patient/family, these areas are particularly important. There can be a different quality to the visit if it takes place in something like a living room instead of a bedroom. And the opportunity to go to the coffee shop together can make the visit into a social event and sometimes give a family something to do together when they've run out of things to talk about[1] or when conversation has become tense or unhappy, and a break is needed.

Excursions and Visits Outside the Institution

The case of Mrs. Barth illustrates the importance of staff activity to insure that residents and patients are able to maintain pre-institutional patterns of visiting the homes of their families. For Mrs. Long the trips out of the home with her surrogate daughter became one of the mainstays of her existence.

With Mrs. Barth we saw the staff working deliberately and cooperatively to insure that there were no institutional obstacles to her going to the family party. Such obstacles do exist: State and Federal reimbursement regulations have made extended visits to the homes of family problemmatic. In many institutions, the fear of malpractice or negligence charges has led to a policy of families signing "Against Medical Advice" forms before taking patients home. In some facilities, policies have been instituted which require that, if the patient becomes ill while on a visit, she must be taken to an acute treatment hospital, rather than be brought back to the facility.

Many families in the study reported that institutional red tape had become an insurmountable obstacle in the path of overnight or weekend visits.

> Mom's heart isn't good, and she's scared of being away from the home for too long. We used to be able to talk her into staying with us overnight—on Thanksgiving, Christmas, Easter—times like that. It made things so much easier for her and for us if we could pick her up the night before and get her all settled in and rested.
>
> Now with the forms we have to sign and the hassle about her medication and what will happen if she gets sick—it's gotten to a point where she comes much less often and then only for a few hours.
>
> I understand why rules and regulations are necessary—but there does seem like too much unnecessary red tape.

I interviewed the mother; she was, as her daughter described her, scared about her heart condition, fearful of being away for too long from the doctors and nurses who took care of her in the facility. Yet, her face came alive with joy as she told me about the holiday gatherings at her children's homes, and on her dresser top were photographs taken at these gatherings.

I interviewed staff and looked at the A.M.A. form which families were required to sign and at the regulations limiting the supply of medications a patient and her family could take with them and at the procedure prescribed if the patient became ill while away from the institution. I tried to put myself in the place of the daughter: What if her mother became ill during the night? My doctor doesn't know her. Would he come? Could we get an ambulance? What would being taken to a strange hospital do to her? She has had heart attacks since she came into the home. Everyone knows her; she knows all the staff; she knows the intensive care unit in the infirmary where she has been taken before.

[1] Weinberg, Jack. What do I say to my mother when I have nothing to say? *Geriatrics*, November 1974.

Would I sign the A.M.A. form? Urge my mother to come? Take the risk myself? On the other hand, if I knew, were she to become ill when she was visiting us, that we could count on the home to help us, to let us bring her back immediately, to tell us what to do and how to do it, would it make it easier?

I looked again at the study findings: Forty percent of the families and old people reported visits to relatives' homes and 25 percent reported excursions to nearby restaurants, sightseeing rides, etc. There were three characteristics that seemed to distinguish these families and old people from the rest of the sample. The families *tended* to be stable middle and upper middle class; they had family doctors they could call on; they lived in neighborhoods served by good hospitals; they saw themselves as having access to help if they needed it. And/or the physical and mental health status of the old person was good. And/or the family gatherings had been so important a part of the life history of the old person that maintenance of this pattern was essential to her mental health.

Mrs. Kaye, for example, was wheelchair-bound, but her family was large and had financial resources. They paid for an aide so that Mrs. Kaye could attend family gatherings. Mrs. Long's functional health status—until near the end—was good, and her need to get out of the institution overrode any fears she and her surrogate daughter might have had. Mrs. Barth was fearful of being away from the institution once she was in it, but, like the Kaye's, her family had both the will and the resources to sustain her in her visits to their homes.

Mrs. Porter's daughter and son-in-law did not have the resources that either the Kaye's or the Barth's had, and she, like Mrs. Kaye, was wheelchair-bound. Yet the nurse and the social worker and the daughter were in complete agreement that Mrs. Porter's mental health, such as it was, depended in large measure on continued and continual reassurance that she was not being abandoned by her daughter. And the inclusion of her in the holiday celebrations at her daughter's home was essential to this process of reassurance, precisely because, over the year and amidst all the strains and deprivation in the lives of Mrs. Porter and her daughter, their gatherings had been times of re-affirmation of the familial ties that bound them together.

Institutional rules were bent to make Mrs. Porter's visits to Mrs. Richard's home possible; an institution vehicle equipped to transport wheelchair patients was commandeered; the Ladies Auxiliary provided funds to pay the driver and an aide, since this was not a formally sanctioned staff assignment. On almost every count, this was a less than ideal situation—but staff came through, motivated by their recognition of the importance of these visits to Mrs. Porter and her family, and their certainty that, without staff help, the family could not perform its role.

Summary

Examination of institutional policies, provisions, and facilities provided stark evidence of the extent to which these items deliver a message to families that the institution welcomes their presence and regards them as partners. In unintended ways the real commitment of the institution to the partnership can be subverted by staff attitudes expressed in the way they respond to families; by policies which serve institutional, rather than human, needs; by the lack of provisions and the help families and old people require.

Staff members—with the best will in the world—may not be sensitive to the institutional obstacles to maintenance of family relationships. Making certain that channels of communication between the institution staff and families and friends and among staff remain open and used is one way of monitoring the institution-family partnership. Periodic reviews of policies is another, if the reviews are done with these kinds of questions in mind:

Is this policy really necessary?
How does it affect the ability of families and friends to do things which make a difference to patients and residents?

Chapter 6. Family Programs

Let's look first at some examples of family programs and then at the purposes they serve.

- Many long-term care facilities schedule special entertainment for Sunday afternoons—a play or musical program presented by the residents themselves or by community groups, such as amateur drama clubs, students from nearby colleges and schools, professionals who volunteer their services. Sometimes the relatives include accomplished musicians who present concerts as their contributions to the home. Sometimes the Sunday afternoon family program is nothing more than a refreshment hour, with the time spent socializing over coffee and cookies.
- Exhibits of the work of residents and patients in arts and crafts and occupational therapy can become "happenings" in a long-term care facility. Modeled after an art gallery's showing or a museum opening of a new exhibit, the long-term care facility can begin with an opening day, complete with guides, a social hour, and name tags mounted next to the work of each resident.
- Religious services can be open to families and friends as well as residents and patients, giving families for whom going to Church or Synagogue together was an important part of their family life the opportunity to maintain this pattern.
- Holiday celebrations can be made into family programs; the Fourth of July and Labor Day may be sponsored by facilities which have outdoor areas. Mother's Day and Father's Day are natural events for celebration in a long-term care facility, and the inclusion of families in these celebrations is all but mandatory.

It's difficult for institutions to invite large numbers of families to events like Thanksgiving or Christmas dinner, or, in Jewish Homes, the Passover Seder. The dining rooms often do not permit the serving of many additional people, and often this kind of family program is not feasible. But some long-term care facilities have staggered invitations, inviting some families to one dinner, others to another, so that over the course of a year, every family has been invited once.

Early evening New Year's Eve parties have proved to be gala events in many facilities. A 7:00 to 9:00 p.m. or 8:00 to 10:00 p.m. party permits many families to join with their aged relatives in celebration of the incoming year, and then go on to their own parties. In one facility in New York City, two energetic, dedicated staff decided to hold a New Year's Eve party in their unit of 40 patients. This was in a municipal long-term care facility, where, in fact, there is a higher percent of the familyless than is true in most voluntary homes and many proprietary long-term care facilities in New York City. Patients were involved in the planning; signs announcing the party were posted on the unit; and invitations were sent to families and friends whose names and addresses appeared in the institution records or were given to the staff by the patients themselves.

Within less than an hour after the party started, the ample supply of refreshments had disappeared and staff members were frantically scurrying around for more. Why? Because everyone, staff and patients alike, had grossly underestimated the number of relatives who would come. The nurse and the social worker were rarely on the unit after 5:00 p.m. or on weekends. Visits of friends and relatives were not recorded on any of the charts. The staff who planned the party therefore had no idea of the number of their patients who had visitors or of the number of visitors.

Moreover, there were relatives and friends who came that night who had never visited before or who visited rarely. They were touched by the invitation; it was the first time an invitation from the facility had been mailed to them. I think we can assume that some of them realized, perhaps for the first time, that they were important people to the patient. And some, maybe because the institution is a large public one, perhaps forbidding in appearance, had not felt that the institution itself welcomed their presence or had not themselves felt comfortable as visitors. What a lesson there was to be learned from that gala evening!

- Special events, some unique to long-term care facilities and old people, some patterned

after familiar community events, have proved successful. One home, blessed with a large and neatly landscaped area, sponsors an annual summer Strawberry Festival. The relatives and friends of the residents and patients receive individual invitations; the Board of Directors and the volunteers come; and the families of all staff are invited.

Another home has an annual exhibit of the memorabilia of patients and residents who wish to participate. Faded family portraits, old Family Bibles, immigration papers, prized letters, awards and plaques, newspaper articles, wedding announcements, diplomas, organization membership cards—these are examples of the items which are placed on display, each carefully tagged with the owner's name. The exhibit opens with a Sunday afternoon reception and lasts for several weeks.

Grandparents' Day and other programs may be designed with the younger generations of the family in mind. In one home, the Day was held on a Sunday in early June. The grounds were transformed into a carnival complete with games of chance and skill, pony rides, merry-go-rounds, and carnival food—hot dogs, hamburgers, cotton candy. The event was widely publicized and invitations sent to all relatives and friends of the residents and patients and to the Board of Directors and supporters of the home.

On the first Grandparents' Day, the home staff had an experience similar to that of the nurse and social worker who organized the New Year's Eve Party. A large group of volunteers and staff were on tap to act as surrogate families, and the staff estimate was that as many as 50 of the 400 patients and residents would need surrogates. The volunteers and staff stayed ready; by the end of the day, six had been needed. There were more residents and patients who had no families present—at maximum 10 more—but they had friends in the home, and the families of their friends included them in their family groups for the day. No staff or volunteer help was needed in these cases; the invitation to join the family had already been extended by either the old person or one of her relatives.

This is by no means an exhaustive list, nor does it give more than a glimpse of the creative approaches to family programs which have been developed. But the list and the descriptions provide the basis for discussion of the purposes of these programs:

(1) The programs provide another way to articulate the partnership between families and friends and the institution.

(2) The programs testify to the fact that the welcome mat is out, that the facility is not a closed institution, a world unto itself.

(3) The programs provide an opportunity for the old and their families to enjoy life together; if this purpose is well served, that in itself is justification for the program.

(4) The programs are one more way of emphasizing the old person's role as family member, as friend. They serve to remind the old, their families, and *the staff* of the individuality of each resident and patient, of each one's own unique life history and family groups.

(5) Particular activities like the Sunday afternoon programs can ease tension, extend the duration of the visit, give the family and the old person something to do when they run out of things to talk about. All of us who have worked in a long-term care facility have witnessed families sitting in uneasy silence after the first 10 or 15 minutes. All of us have watched relatives use the visits as times to get caught up on each other's news, while the old person sits silent in the periphery of the family group.

And sadly, we have seen visits become the battlegrounds on which the family fights of years back are reopened and reinfected. I am not suggesting that visits can or should be all sweetness and light, in that staff should act like parents of small children, using diversionary activities to break up squabbles between siblings. It has seemed to me, however, that Sunday afternoons, with other residents and patients and their families nearby, is not the best time for family fights, nor a time which offers the opportunity for resolution of problems.

To summarize: There are many forms that family programs can take—from a simple refreshment hour on a Sunday afternoon to an elaborate Grandparents' Day and Strawberry Festival. They require investment of staff and volunteer time, proper facilities, and often an allocation of funds. But those of you who have developed such programs can testify to their value. The facility benefits because family programs give it a chance to put its best foot forward. The residents and patients and their families and friends benefit. And in the end, staff does, too, despite the work involved, for the program affirms both the importance of their work and the partners who share the work with them.

Chapter 7. Summary

In this summary chapter of Part I, it is important to talk about the mental health implications of maintenance of the relationships between old people in institutions and their families. What is the pay-off to the aged themselves, to their children and grandchildren and great-grandchildren? Are there societal values which must also be included in this equation?

The cases I used for purposes of illustration included no miracles: Mrs. Long died surrounded by her family, but the claim cannot be made that the pathology of her family relationships had been cured, nor that her sons and daughters-in-law will not carry the scars marking the wounds inflicted during the years of family stress. Mrs. Barth would not rank high on a test of morale, despite the fidelity of her family to her.

Miss Farrell, on the other hand, probably would do well on such a test, yet she has only relatives, not family, with whom contact is limited to the observance of the amenities of middle-class, genteel Americans. A comparison between Mrs. Barth and Mrs. Long alerts us to the fact that the conclusions in this chapter cannot be the "elegant" ones we might have wanted: No claim can be made that a linear relationship exists in all cases between the existence and maintenance of familial relationships and the mental health and morale of the old person in the institution.

What then can be said?

First, in the course of collecting the data for the study on which this manual is based, we got to the point where we knew, as we entered the old person's room, whether she still had family and friends who maintained contact with her. The family pictures, the plants, the food treats, the private phone, the radio, the television set were the markers, the evidence that, despite the fact that she lived in an institution, she was still an individual who had a place in a family or friendship group.

In a similar fashion, we could walk around the institution—down the halls, in the lounge areas and coffee shops, in the lobby itself—and get a sense of whether this was an institution which welcomed families and regarded them as partners. If it were a weekday morning and we saw a middle-aged daughter walking down the corridor with her mother, if we were in the lounge and saw a family group visiting, if we glanced into rooms on skilled nursing floors and saw visitors in these rooms, if we drove into the visitors' parking lot and saw numbers of cars, we knew that, when we interviewed the families in our sample in these institutions, we would find that most of them would be experiencing the institution as a place in which they felt welcome and which encouraged their continuing performance of familial tasks.

All of this is, I think, obvious, but then another implication of what we were seeing struck us. Shanas and her associates wrote in the introduction to their study of *Old People in Three Industrialized Societies:*

> The basic preoccupation of social gerontology as it has emerged within the last two decades may be categorized as being concerned with integration versus segregation. Are old people integrated into society or are they separated from it? This is perhaps not only the most important theoretical question in social gerontology today but also the key question affecting all social policies concerning the aged.[1]

Long-term care facilities for the aged are faulted frequently not only on the grounds that I talked about in the third chapter of this manual, that is, that they serve as dumping grounds for the unwanted. They are faulted also because they are perceived as an archetypical age-segregated arrangement. People describe the facilities as depressing because they see them as places where old people are herded together in a world inhabited only by the old, devoid of the spice of the variety of different age groups. We know that this is not an accurate picture, because, to use the language of the sociologist, it does not include one important group of actors in the system—the staff, an age-heterogeneous group in constant face-to-face contact

[1] Shanas, Ethel; Townsend, Peter; Wedderburn, Dorothy; Friis, Henning; Milhoj, Paul; and Stehaubver, Jan. *Old People in Three Industrial Societies.* New York: Atherton Press, 1968, p. 3.

with the old. As we all know, the relationships between staff and residents and patients are often not just instrumental and professional, but frequently include mutual feelings of affection and concern.

Even granting that the institution is, in fact, a community composed of both residents and patients and staff, and is, therefore, more heterogeneous with respect to age than it is perceived to be by outsiders looking in, it can, in Goffman's words, be a "total institution"[2]—closed off from the rest of the world, in Shanas' words—"separated from society." This is indeed an important theoretical consideration and should be, as Shanas and her associates argued, a "key question affecting all social policies concerning the aged." The institution which welcomes the presence of families and their sharing in the function of the care of their aged members is, by these policies, breaking down institutional barriers to the continued integration of the aged in society, is creating as age-heterogeneous a community within the institution as is possible.

I emphasize this point; most discussions of this issue in gerontology are directed to finding ways to maintain the aged in the community. And such efforts are important. Yet even the most anti-institutionalization gerontologists recognize, as did Blenkner, that "There will always be some for whom group living in a highly protected setting is the preferred or necessary way of life. . . ."[3] Recognizing this reality, the social policy questions become ones of how to create a social community within the institution and how to guarantee that this community is integrated in all ways possible into the larger community of which it is a part.

The daily presence of families and friends from the outside, inclusion of them, along with the aged and the staff, as actors in the system, defining tasks which are still theirs, and making certain that their efforts to perform these tasks are supported—these are the guarantees that, though the old person lives in a long-term care facility, she is neither segregated from the people who were, and are, important to her, nor from the community of which she was a member.

Second, the entry of the old person into the institution does, of course, represent a shift in the nature of the responsibilities which the family will carry and those which the institution is assigned. There are those who are concerned about social value questions which emerge from this shifting of responsibility: Does the existence of our institutions contribute to the destruction of a sense of responsibility of the young for the old? Are we encouraging families to define too narrowly the limits of these responsibilities? Are we socializing the young in such a fashion that only the most fragile, pro forma relationships will tie one generation to the other?

My colleague, Phyllis Caroff, D.S.W., and I wrote about this in *Anticipatory Grief.* We were talking about the role of the social worker in working with the terminally ill aged person and her family:

> We must now deal with a penumbra of the reality of the extended-care facility system and the variety of actors within it. There are among the families encountered those who *do* use the institution as a "storage dump" for the mother or father who long ago had lost the love and respect of their children, and whose entry into the institution signaled, but did not cause, exclusion from the members of the family group, and their children's reconstruction of their own lives without their parents. Such behaviors may be reinforced by the appropriate valuing in our society of being in touch with real feelings and being able to accept them. The daughter may say, "My mother was a selfish, bitter woman who never gave us the love and care we needed but expected us to do everything for her. I've made my peace with this, and I've got a good life now. I don't love her and you can't expect me to pretend I do."
>
> We must ask ourselves whether the value placed on awareness and acceptance of a person's own feelings carries with it the freedom to act on these feelings without consideration of the consequences of so doing. This is doubtful. . . . [We] . . . are "carriers of the cultural norms" [and must] . . . reach out, to explore the reasons for absence of involvement, and to support that side of the ambivalence which will encourage a new interaction. . . .[4]

[2]Goffman, Erving. *Asylum: Essays on the Sound Situations of Mental Patients and Other Inmates.* Chicago: Aldine Publishing Company, 1961.

[3]Blenkner, *op cit.,* p. 58.

[4]Caroff, Phyllis, and Dobrof, Rose. Social work: Its institutional role. In: Schoenberg, Bernard et al., eds. *Anticipatory Grief.* New York: Columbia University Press, 1974, pp. 259-260.

We look back at the Long family and the Gross family: Mrs. Long's children have the comfort of knowing that, although they were in touch with their real feelings and able to accept them, in the end, they did what was right according to their beliefs. They can say to their children and grandchildren that, although they did not love their mother, they did not abandon her; they did what was expected of them. The Gross family, at this writing, will not have this comfort: Mrs. Gross's step-grandchildren will not have known the woman who was mother to their parents. They will not have been raised in a family in which there is both acceptance of feelings *and* consideration of the consequences to others of actions based only on feelings, not on feelings plus normative standards of behavior.

H. H. Gerth and C. Wright Mills in their "Biographical View" of Max Weber capture the essence of what I am saying. They were writing about the impact of Freud's work on Weber:

> Full of sympathy for the tragic entanglements and moral difficulties of friends . . . Weber reacted sharply against what appeared to him a confusion of valuable though still imprecise, psychiatric insights with an ethic of vulgar pride in "healthy nerves." He was not willing to accept healthy nerves as an absolute end, or to calculate the moral worth of repression in terms of its cost to one's nerves. . . . He believed that many of those who followed in the wake of Freud were too ready to justify what appeared to him as moral shabbiness.[5]

Whether we are talking about the ethical imperatives which should inform our society or the mental health needs of the old people in our institutions and their families, we cannot accept "moral shabbiness" or an assessment of behavior based only on the cost to one individual's "nerves." Institutions which welcome families as partners, which take into account the psychological tensions in family relationships and yet still encourage families to do what they can and what they believe they should, are articulating an ethical imperative governing intergenerational relationships. And this is a pay-off, the value of which can neither be measured with precision nor underestimated.

Third, I have said that we could always tell when we were entering the room of an old person who was still part of a family group. The important point is that it was clear that these people were getting more—both emotionally and in tangible possessions and services—than the institution itself could provide. Even in the best of institutions with the most resources available, the finest staff and facilities, there is a limit to what the formal organization can do and can provide. Most of the old people whom we interviewed, who said that the decision to enter the institution was the right one and who described themselves as reasonably satisfied with their lives, were people who had *both* the care provided by the institution and families and friends who did things for them.

There were, of course, exceptions to that generalization. There were people like Miss Farrell who really didn't seem to need primary group relationships and who were content with what the institution could provide. There were others (I have not presented cases to illustrate this group) whose lives outside the institution had been so hard that the guarantee of basic maintenance—food, clothing, shelter, medical care—made the institution a true haven for them. And there were the Mrs. Barth's who had the best of institutional care and a large and faithful family and yet who still grieved for a dead husband, an apartment, and who could not make new friends or find new roles. And there were the Mrs. Gross's who, having been abandoned, had made the institution their homes and created surrogate family groups within the institution.

Granting these exceptions, the old people who had both institution and families were more likely to have the extras that are important in the lives of most of us. And more than that, we found, as did Leonard Gottesman and his associates in their studies of the determinants of the quality of care provided in long-term care facilities that the institutionalized aged who had families who visited regularly were more likely to get better care from the staff than were those without families or with families who rarely visited.[6] One son visited his mother weekly even

[5]Gerth, H.H., and Mills, C. W. *From Max Weber: Essays in Sociology.* New York: A Galaxy Book of Oxford University Press, 1958. p. 20.

[6]Gottesman, L.E. Nursing Home Performance as Related to Resident Traits, Ownership, Size and Source of Payment, Paper presented at the 100th Annual Meeting of the American Public Health Association, Atlantic City, N.J., November 15, 1972.

though she was severely impaired mentally and did not always know who he was, and even though his visits wracked his soul. He put it best:

> No, I'm never sure that she knows who I am, or even that I'm there. Sometimes she thinks I'm her brother; sometimes, she gets me mixed up with my other brothers, and there've been times when she thinks I'm my father who's been dead 30 years. Sometimes there are moments when she knows it's me, but even those times hurt. It's murder to see her like this, and I wish it were over, because the woman who was my mother isn't really there anymore.
>
> But I keep coming. She's been there for 8 years and I've watched a lot. Some of the staff—most of them, in fact—are decent people, trying to do a good job. God, sometimes I don't see how they stand it. But they're human, too, and it's easy to fall into a pattern of neglect of someone like my mother, where nothing really seems to make any difference. I come to keep them honest. I know if they know that I come regularly, they'll keep her clean and dry and comfortable. They know me, and I know them; I give gifts at holiday times. I don't want them to think of my mother as C-12 [her room number] or as a vegetable—even though that's how she seems to me sometimes.
>
> It works, doing it this way. My wife and I can't give her the care she needs. We have to count on the people here, so I keep coming. It's not much, but it's all I can do.

We all know exceptions to what this son was saying and what Gottesman and his associates found in their study. That is, we all know people like Mrs. Gross who are the abandoned, the alone; staff members do become surrogate families and do exert extra efforts on their behalf. We might wish also that what the son was saying was not true, that it does not require the presence of families to keep us and our colleagues "honest"—responsible and caring in our relationships with the aged in our institutions.

But the kernel of truth in what he was saying, I think we cannot deny. Hence, the aged who have both the institution staff and their families will in general do better not just because they have the resources of both available to them, but also because as the institution establishes norms of what is expected from families, so also the families can help staff live up to their responsibilities.

Fourth, and now in these last paragraphs I return to the introductory chapter to this manual. The sense of pride in work which sustains staff is enhanced if we work in partnership with families, if we do not perceive ourselves or are perceived by others as "keepers of warehouses for the unwanted." And our perception of ourselves and our institutions is an item in the *elan* of the community which the institution is. We set the tone; our morale *is* important; the psychosocial environment we help create can be therapeutic or it can be sterile and deadening to the human spirit. Thus there is pay-off to the staff from this partnership, and that pay-off is then registered in the quality of care we provide.

Appendix I — Application and Intake Forms

In the appendix you will find first a copy of the Application for Admission and copies of forms used during the intake process at The Hebrew Home for the Aged at Riverdale in New York City. I am indebted to Jacob Reingold, executive vice-president of the Home, and to Mrs. Marcia Jacobs, director of the Social Services Department, for permission to use these materials.

The Home is a large one, with a bed capacity of over 700, and with both health related and skilled nursing facilities, located in a number of different buildings. The staff is also large and written communications and staff team conferences are essential if needed information is to be properly disseminated to staff. In smaller facilities, it may not be necessary (or possible) to have this formalized and extensive system of written communication.

I have included these materials from The Hebrew Home for the Aged at Riverdale, however, because they may be useful to you in reviewing your own procedures for securing information about family composition and relationships and communicating this information to your staff. You will find also that the interview guides used by the intake staff sensitize the worker to the need for attention to family composition and relationships.

Date _____

APPLICATION FOR ADMISSION

TO

THE HEBREW HOME FOR THE AGED

AT RIVERDALE

Please answer all questions completely and accurately. **PLEASE PRINT... DO NOT WRITE**

1. Name _____ 2. Sex _____ 3. Date of Birth _____

4. Address _____
City State Zip Code

Former Address

_____ From _____ To _____

5. Social Security and/or Medicare No. _____

6. _____

_____

7. Marital Status: Single _____ Married _____ Widowed _____ Divorced _____ Separated _____

Marriages:

Date	Place	Name of Spouse	How Terminated and Date of Termination

8. How many children living _____ Sons _____ Daughters _____

How many children deceased _____

Name	Date of Death	Age at Death

Soc Svc Form No.3, 1 September 1974

EXHIBIT

60

APPENDIX I

LIST ALL CHILDREN

A Name _____ Age _____

Address _____
CITY STATE ZIP CODE

Phone No. _____ Education (last grade completed) _____

Occupation _____ Employed by _____

Please Check: Owner _____ Partner _____

Business Address _____ Bus. Phone No. _____
CITY STATE ZIP CODE

Spouse's Name _____ Occupation _____ Employed by _____

Spouse's Bus. Address _____ Bus. Phone No. _____
CITY STATE ZIP CODE

CHILDREN	Age	Single	Married	Living with Parents
1.				
2.				
3.				

B Name _____ Age _____

Address _____
CITY STATE ZIP CODE

Phone No. _____ Education (last grade completed) _____

Occupation _____ Employed by _____

Please Check: Owner _____ Partner _____

Business Address _____ Bus. Phone No. _____
CITY STATE ZIP CODE

Spouse's Name _____ Occupation _____ Employed by _____

Spouse's Bus. Address _____ Bus. Phone No. _____
CITY STATE ZIP CODE

CHILDREN	Age	Single	Married	Living with Parents
1.				
2.				
3.				

C Name _____ Age _____

Address _____
CITY STATE ZIP CODE

Phone No. _____ Education (last grade completed) _____

Occupation _____ Employed by _____

Please Check: Owner _____ Partner _____

Business Address _____ Bus. Phone No. _____
CITY STATE ZIP CODE

Spouse's Name _____ Occupation _____ Employed by _____

Spouse's Bus. Address _____ Bus. Phone No. _____
CITY STATE ZIP CODE

CHILDREN	Age	Single	Married	Living with Parents
1.				
2.				
3.				

EXHIBIT

LIST ALL CHILDREN (CONTINUED)

D Name _____ Age _____

Address _____
CITY STATE ZIP CODE

Phone No. _____ Education (last grade completed) _____

Occupation _____ Employed by _____

Please Check: Owner _____ Partner _____

Business Address _____ Bus. Phone No. _____
CITY STATE ZIP CODE

Spouse's Name _____ Occupation _____ Employed by _____

Spouse's Bus. Address _____ Bus. Phone No. _____
CITY STATE ZIP CODE

CHILDREN	Age	Single	Married	Living with Parents
1.				
2.				
3.				

E Name _____ Age _____

Address _____
CITY STATE ZIP CODE

Phone No. _____ Education (last grade completed) _____

Occupation _____ Employed by _____

Please Check: Owner _____ Partner _____

Business Address _____ Bus. Phone No. _____
CITY STATE ZIP CODE

Spouse's Name _____ Occupation _____ Employed by _____

Spouse's Bus. Address _____ Bus. Phone No. _____
CITY STATE ZIP CODE

CHILDREN	Age	Single	Married	Living with Parents
1.				
2.				
3.				

F Name _____ Age _____

Address _____
CITY STATE ZIP CODE

Phone No. _____ Education (last grade completed) _____

Occupation _____ Employed by _____

Please Check: Owner _____ Partner _____

Business Address _____ Bus. Phone No. _____
CITY STATE ZIP CODE

Spouse's Name _____ Occupation _____ Employed by _____

Spouse's Bus. Address _____ Bus. Phone No. _____
CITY STATE ZIP CODE

CHILDREN	Age	Single	Married	Living with Parents
1.				
2.				
3.				

EXHIBIT

9. Do all above know about this application _____

10. Other interested relatives or friends

Name	Address	Phone No.	Relationship

11. Education: Number of Years of Schooling _____

Country and City where educated _____

12. Last Occupation _____ From _____ To _____

Reason for discontinuing work _____

Most common occupation (if different from above) _____

Date discontinued work _____

Spouse's occupation _____

13. Current Means of Support: Savings _____

Social Security _____
(Amount S. S. Number)

S. S. I. or Medicaid No. _____
(Amount - Case Number - Dept. of Social Services Center)

Private Pension or Annuity _____
(Amount Source)

Others (give details) _____

14. Plan for Support in the Home _____

15. Do you have money in any Banks? _____

Name of Bank	Address	Account No.	How Much

EXHIBIT

63

16. Did you have money in any Banks? _____

Name of Bank	Address	Date Account Closed

17. Do you have a Safe Deposit Box? _____

Where? _____ What is in it? _____

18. Do you have Securities _____ Investments? _____

Real Estate? _____ Cash on Hand? _____

Describe fully _____

19. Is anyone holding money or property for you? (Explain) _____

20. Have you in the last 10 years given away money, insurance, or real or personal property?

What	To Whom	When

21. Are you insured? _____

Company	Amount	Policy Number	Who Pays Premiums?

22. Do you belong to any Society, Lodge, Trade Union or other Organizations or Clubs? _____

Name of Organization _____

Secretary _____ Address _____ Phone No. _____

Benefits _____ Annual Dues _____

Name of Organization _____

Secretary _____ Address _____ Phone No. _____

Benefits _____

Name of Organization _____

Secretary _____ Address _____ Phone No. _____

Benefits _____

23. Do you have a reserved grave? _____

Where? _____

Where is the deed? _____

24. Are you suffering from any illness or handicap? (Explain) _____

_____

25. Who is your family doctor? _____

Address: _____

26. Have you been in a hospital in the last 5 years? _____

Name of Hospital	From	To	Reason

27. Why do you want to enter a Home for the Aged? _____

_____

_____

_____

How did you learn about this Home? _____

_____

_____

_____

EXHIBIT

343-982 O - 77 - 5

28. Have you ever been in any Home? _____

From _____ To _____

29. What are your interests or hobbies? _____

_____

_____

_____

Date _____

I hereby apply for admission to The Hebrew Home for the Aged and solemnly affirm that all the above information given is full, accurate, and truthful. I agree, if admitted, to abide by all the rules and regulations, the Constitution and By-Laws of the Home as the same may be constituted and exist from time to time.

I also hereby expressly authorize and request any and all insurance companies in which I am insured, or which hold funds of mine payable to me; and any and all banks and bankers which now hold or heretofore held funds of mine; and any person, firm or corporation which holds funds of mine or payable to me, to give full and detailed information regarding the same to The Hebrew Home for the Aged or its accredited representatives.

_____ _____

Witness Applicant's Signature

In compliance with New York State and Federal laws which prohibit discrimination based on race, creed, color, national origin, sex and sponsor, The Hebrew Home for the Aged at Riverdale admits and treats all residents and patients on this non-discriminatory basis.

EXHIBIT

66

APPENDIX I

SOCIAL SERVICE DEPARTMENT
TELEPHONE INTERVIEW FORM

INTERVIEWER _____ DATE _____

NAME OF APPLICANT _____ REFERRED BY _____

ADDRESS _____

TELEPHONE NUMBER _____

NAME AND RELATIONSHIP OF KEY RELATIVE _____
(Usually the Caller)

ADDRESS _____

TELEPHONE NUMBER _____ BUSINESS TEL. _____

FAMILY PHYSICIAN _____ ADDRESS _____

HOSPITALIZATIONS:

NAME OF HOSPITAL	DATES OF HOSPITALIZATION

CHECKLIST	DATE
1. Packet mailed	
2. Material received	
Application	
Application fee	
Dr's. Exam.	
Hospital Reports	
1	
2	
3	
3. To Dr. Approval for Medical	
4. Medical Appointment Scheduled	
5. Social Service Interview Scheduled	
6. Social Worker	

	DATE
Approved for Committee	
Approved for Admission	
Admitted to Home	

Case Closed
Reason: _____

Comments:

Interest letter sent _____

Form/1—Revised Oct. 1968

EXHIBIT

DATE: _____

SOCIAL SERVICE FIRST INTERVIEW

APPLICANT _____ WORKER _____

Approved Facility: C-U C-1st M.B. Inf. Sta. No Decision

Pending: X-ray Lab Tests Outside Reports Other

Accompanied by:	
Description of Applicant	
State Reason for Application	
Social History	

EXHIBIT

68

APPENDIX I

WORK SHEET

Social History

NAME_____ BIRTHDATE_____ PLACE_____

Father's Occupation: Status:

Mother:

Birth Position: Siblings:

Living Where

Education:

To U.S.

Marriage.

Children:

Death of Spouse:

How Manage:

Retirement:

EXHIBIT

Continued_____

Applicant

Present Budget

Address
How Long Living There
How Many Rooms
Rent
Income
  Social Security
  Pension
  Other
Contributions From Family

Financial Plan

Burial
  Society
    Dues
    Grave
  Burial Fund
  Family Responsibility

Re Spending His Time

  Company

  Activity

  Maintaining Apartment

  Organizations

EXHIBIT

Continued_____
Applicant

Stated Feelings re:

Tour of Home

Religion:

Rooms:
Including sleeping habits

Windows

Activities of Interest:

Applicant Role during Interview

Family Role:

Worker's Evaluation:

PRE-ADMISSION INTERVIEW

APPLICANT_____ WORKER_____

DATE:

REACTION TO ROOM:

RESIDENT WORKER FOLLOW THROUGH

Financial

Medical

Housekeeping

Group Activities

Other (Specify)

SUMMARY OF IMPRESSIONS:

ADMISSION DATE:

APPENDIX I

THE HEBREW HOME FOR THE AGED AT RIVERDALE PALISADE NURSING HOME

DEPARTMENT OF SOCIAL SERVICES

PRE-ADMISSION MEETING

1. NAME:
   AGE.
   AREA:
   INTAKE WORKER:
   SOCIAL WORKER:

2. PERTINENT INFORMATION:

3. SPECIAL ATTENTION:

4. MEDICATION:

5. SPECIAL INTERESTS:

6. INITIAL CARE PLAN:

MFJ/gf
12/76

CONFIDENTIAL

EXHIBIT
73

INTERVIEW—TO SPEND DAY

APPLICANT_____ WORKER_____

DATE:

ACCOMPANIED BY:

ESCORT:

REASON:

REACTION TO:

LUNCH:

ACTIVITIES:

ROOMS:

EVALUATION:

EXHIBIT

APPENDIX I

PROFILE-INTEREST SHEET

RE: _____, RESIDENT Admitted to: _____

TO: Group Activities
Volunteer Service
Workshop

ALEXANDER SHOPPING _____
ARTS AND CRAFTS _____
BINGO _____
BINGO, COMMITTEE SNF, HRF _____
BIRTHDAY PARTY COMMITTEE SNF, HRF _____
BOOK REVIEWS _____
BOWLING _____
CABARET COMMITTEE _____
CHAPEL COMMITTEE _____
CHOIR _____
COMMUNITY MEETINGS _____
COOKING GROUP _____
COUPLES GROUP _____
CURRENT EVENTS _____
DANCE _____
DISCUSSION GROUP _____
DRAMA GROUP _____
ENGLISH CLASSES _____
FILMS _____
GLEE CLUB _____
GOLDEN AGE CLUB _____
INTER-GENERATIONAL GROUPS _____
LIBRARY TRIPS _____

MEN'S CLUB _____
MUSIC APPRECIATION _____
NEW RESIDENT GROUP _____
PING PONG _____
POETRY GROUP
PROGRAM PLANNING (ENTERTAINMENT COMMITTEE) _____
RADIO DISCUSSION SERIES _____
RECEIPT GROUP _____
RESIDENT COUNCIL _____
RESIDENT VOICE NEWSPAPER _____
RIVERDALE SHOPPING _____
SAFETY COMMITTEE FOR RESIDENTS _____
SOCIAL ACTION COMM _____
SPEAKERS COMMITTEE _____
SHUFFLEBOARD _____
SYNAGOGUE SERVICES _____
VOLUNTEER _____
WORKSHOP _____
WORKSHOP DISCUSSION GROUP _____
YIDDISH CULTURE _____
OTHER _____

TRIPS

BALLET _____
BARBECUES _____
BEAR MOUNTAIN _____
BOAT RIDES _____
CONCERTS
LUNCHEONS _____
MOVIES _____
MUSEUMS _____
OPERA _____
PICNICS _____
SPORTS EVENTS _____
STERLING FOREST _____
TEA PARTIES _____

Activity Form 9/1976

EXHIBIT

MEMORANDUM

_____
Date

TO:

FROM:

_____ was admitted to the Home today.

Please note the following relatives:

Name	Address	Phone No.	Relationship

EXHIBIT

Dear _____

You may know me already, but if you do not, I would like to introduce myself as your relative's social worker and to inform you that my new office is located in_____.

My telephone extension is_____.

When you wish to see me, please feel free to call before coming so that we can set up an appointment.

Since you are the relative we are contacting, would you share this information with other family members?

Yours truly,

EXHIBIT

THE HEBREW HOME FOR THE AGED AT RIVERDALE PALISADE NURSING HOME

DEPARTMENT OF SOCIAL SERVICES

SIX MONTH RESIDENT/PATIENT CARE SUMMARY

RESIDENT: _____ SOCIAL WORKER: _____

A. FROM: _____ TO: _____ APX. # OF VISITS: _____

B. LIVING SITUATION: ROOM # _____ HRF: _____ SNF: _____

1. PHYSICAL:

2. EMOTIONAL:

3. INTERPERSONAL:

4. FAMILY:

C. MOBILIZATION OF RESOURCES:

D. CARE PLAN:

D.S.S. 8/76
Revised: 1/77

EXHIBIT

Appendix II – Sample of Handbook for Residents

On the next pages, you will find reproduced a handbook which is given to all applicants and their families at the Frances Schervier Home and Hospital in New York City. I am indebted to Sister Eilharda S.F.P. and Mr. Thomas Coughlin of Schervier for permission to reproduce these pages.

I chose to include this booklet here for two reasons. First, the booklet is not an expensive, elaborate public relations tool for the institution. Most facilities could afford the staff time, supplies, and equipment necessary to produce a handbook like this.

Second, and most important, is the message which Frances Schervier is delivering to the old people and their families and friends. The language itself, the policies, for example, about visiting, the information which is included, all serve to affirm the individuality of the old person and the continuing importance of her family and friends. The message is one of welcome and partnership: There is the clear *expectation* that families and friends will visit and that there will be things that they will do with and for the old person. And there is the *promise* that the institution and its staff will help in this process.

Welcome

to

Frances Schervier

FRANCES SCHERVIER HOME AND HOSPITAL
2975 INDEPENDENCE AVE.
BRONX, N. Y. 10463
TEL: 212 - 548-1700

EXHIBIT
80

Welcome to your new home.

"Peace and all good things."

This traditional Franciscan greeting expresses the concern of the Franciscan Sisters of the Poor and the staff for your happiness. Every effort is made to make this a reality for you. In the next few days you will be visited by members of our staff and they will guide you through the Home. Meanwhile, you will find the answers to some of your questions in this booklet. For your convenience, we have listed items of information alphabetically.

EXHIBIT

BARBER SHOP

is located on the ground floor level. It is open three days a week: Thursday, Friday and Saturday from 9:00 a. m. to 3:00 p. m. The appointment can be made by you or your nursing supervisor.

BEAUTY SALON

also on the ground floor. Appointments are scheduled Monday through Friday from 8:30 a. m. to 4:00 p. m. You may make your own appointment with the beautician or your nursing supervisor will gladly do this for you.

CASHIER'S OFFICE

on the main floor is open Monday through Friday from 9:00 a. m. to 12 noon. (We suggest that you keep very little money in your room.)

CAFETERIA/COFFEE SHOP

is on the ground floor level. Residents can join their visitors for coffee breaks between the following hours:

9:00 a. m. - 10:00 a. m.	2:30 p. m. - 3:30 p. m.

On special occasions you may wish to have lunch or dinner with your family or friend in the cafeteria. The hours are:

11:00 a. m. - 1:00 p. m.	4:30 p. m. - 6:30 p. m.

CHAPEL

The spacious Gothic Chapel, opposite the main entrance, is open for you at all times during the day.

A resident chaplain is available 24 hours a day.

	MASSES
Sundays and Holy Days	6:30 a. m. & 10:00 a. m.
Week Days	6:30 a. m. & 9:15 a. m.

See bulletin boards for the many other religious services.

CIGARETTES

Vending machines are found in the cafeteria on the ground floor. Please observe the smoking regulations.

CLOTHING

We encourage you to have at least six changes of underwear and sleeping garments. Drip dry, polyester dresses, shirts, parts, etc., are appropriate. Clothing will be marked with your name by our sewing department. To avoid loss, all new clothing should be sent to the sewing room to be marked before wearing.

COCKTAIL LOUNGE

Located in the Recreation Hall, open Wednesday and Thursday afternoons between 3:00 p. m. and 4:00 p. m. Visitors are invited to join their relatives there.

DINING ROOM

A professional dietician plans and supervises nutritious meals served in dining rooms located on each floor. Special diets are prepared as needed.

Breakfast	7:30 a. m. - 8:30 a. m.
Dinner	12:15 p. m. - 1:30 p. m.
Supper	5:30 p. m. - 6:30 p. m.

GIFT SHOP

is located on the ground floor level, open Monday through Friday and on Sundays from 11:30 a. m. to 3:30 p. m. Gifts of all kinds and articles for personal necessities.

GRATUITIES (Tipping)

Employees are not permitted to accept tips from residents or visitors. We ask your cooperation in helping us uphold this basic rule of hospitality.

LAUNDRY

Towels and linens are provided. The Home furnishes personal laundry service without additional charge. However, you or your relatives are requested to take care of clothing requiring dry cleaning.

LIBRARY

is located on the northeast corner of the main floor and is open every day until 10 p. m. Large print books, magazines and newspapers are available.

LOUNGE

Located near the main entrance, a cheerful family room, furnished by the Ladies' Auxiliary, is open for your use at any time.

MAIL

is delivered once a day after lunch. Stamps may be purchased at the switchboard.

MEDICAL CARE

A resident physician is available at all times. You will be assigned an attending doctor who will be responsible for your medical care. In the Nursing Home area the doctor visits you at least once a month and more often if necessary.

NEWSPAPERS

are available daily from the vending machines located in the cafeteria. (For further information on newspapers, please contact the receptionist in the main hall.)

NURSING CARE

Nurses are on duty 24 hours a day. Your nursing supervisor is _____.

RECREATION

A variety of social activities and entertainments are scheduled each week. Some of these activities will take place on your floor; others on the ground floor in the Recreation Hall. (Also, watch your bulletin boards.)

SECURITY

Residents may keep their individual closets private and everyone will receive a key on admission.

SMOKING

is restricted to approved areas that are clearly marked. Your cooperation in this matter is requested.

SOCIAL SERVICE

Offices are located on the main floor. Your social worker is _____.

TELEPHONE

Public phones are located in the lobby of the main floor as well as the 2nd floor (St. Rose Hall) and the 7th floor. The phones on the 2nd and 7th floors are especially arranged for the convenience of wheel chair residents. We regret that personal telephone calls may not be made or received on individual floors.

THERAPY

Occupational and physical therapy is available on the 7th floor. Your social worker or your nurse will be happy to introduce you to the staff there. A roof garden is also located on the 7th floor and is open during the summer from 9 a.m. until 3:30 p.m.

VISITORS

including children of all ages, are welcome at any time during the day.

Fire Department regulations state that electrical cooking or heating devices may not be kept in the residents' rooms nor is smoking permitted in their rooms.

Bibliography for Part I

Adams, Bert N. *Kinship in an Urban Setting.* Chicago: Markham Publishing Co., 1968.

Anshen, Ruth Nanda. ed. *The Family: Its Function and Destiny.* New York: Harper & Row, 1959.

Bell, Norman W., and Vogel, Ezra F., eds. *A Modern Introduction to the Family.* New York: The Free Press, 1968.

Bennett, Ruth, and Nahemow, Lucille, eds. Socialization and social adjustment in five residential settings for the aged. In: Kent, Donald P. et al. *Research Planning and Action for the Elderly.* New York: Behavioral Publications, 1972. pp. 514-525.

Berezin, M., and Cath, Stanley, eds. *Geriatric Psychiatry,* New York: International Press, 1965.

Blank, Marie. Psychotherapy with aged persons: A selective review of the literature. *Geriatrics,* November, 1974, Vertical File.

Blank, Marie. Recent research findings on practice with the aging. *Social Casework,* June, 1971.

Blau, Z. Structural constraints on friendships in old age. *American Sociological Review,* 1961, 26:429-439.

Blenkner, Margaret. Social work and family relationships in later life with some thoughts on filial maturity. In: Shanas, Ethel, and Streib, Gordon, eds. *Social Structure and The Family: Generational Relations.* Englewood Cliffs, N.J.: Prentice-Hall, 1965. pp. 46-62.

Boureston, Norman, and Gottesman, L.E. Aged Patients and Nursing Home Services: Design and Methodology. Paper presented at the 100th Annual Meeting of the American Public Health Association, Mental Health Section, Atlantic City, N.J. Nov. 15, 1972.

Brody, Elaine. The Aging Family. Paper presented at the 19th Annual Meeting of the Gerontological Society, New York, November, 1966.

Brody, Elaine. Aging. *Encyclopedia of Social Work,* Vol. 1, Robert Morris (editor-in-chief), New York: NASW, 1971, pp. 51-74.

Brody, Elaine M. and contributors. *A Social Work Guide for Long-Term Care Facilities.* National Institute of Mental Health. DHEW Publication No. (ADM) 75-177. Washington, D.C.: Superintendent of Documents, U.S. Government Printing Office, 1975.

Butler, Robert N. *Why Survive? Being Old in America,* New York: Harper & Row, 1974.

Cath, Stanley. Psychoanalytic viewpoints on aging—an historical survey, In: D. Kent, R., Kastenbaum, and S. Sherwood, eds., *Research Planning and Action for the Elderly: The Power and Potential of Social Science.* New York: Behavioral Publications, 1972. pp. 279-314.

Carp, Frances M., ed. *The Retirement Process: Report of a Conference.* National Institute of Child Health and Human Development. Washington, D.C.: Superintendent of Documents, U.S. Government Printing Office, 1966.

Coser, Rose Laub, ed. *The Family: Its Structures and Functions.* New York: St. Martin's Press, 1964.

Dobrof, Rose, ed. *Aged Patients in Long-Term Care Facilities.* National Institute of Mental Health. DHEW Publication No. (ADM) 75-154. Washington, D.C.: Superintendent of Documents, U.S. Government Printing Office, 1974.

Falck, Hans S., and Kane, Mary K. *It Can't Be Home: Social and Emotional Aspects of Residential Care.* National Institute of Mental Health. DHEW Publication No. (HSM) 73-9116. Washington, D.C.: Superintendent of Documents, U.S. Government Printing Office, 1973.

Friedsam, Hiram J., and Dick, Harry R. Aspects of relatives' participation in admission to two homes. In: Leeds, Morton, and Shore, Herbert, eds., *Geriatric Institutional Management.* New York: G. P. Putnam's Sons, 1964. pp. 398-406.

Glick, Paul. A demographer looks at American families. In: *Journal of Marriage and the Family,* February, 1975. pp. 15-26.

Goldfarb, Alvin I. Current trends in the management of psychiatrically ill aged. In: Hoch, P., and Zubin, J., eds., *Psychopathology of Aging.* New York: Grune & Stratton, 1961. pp. 248-265.

Goldfarb, Alvin. Psychodynamics and the three-generation family. In: Shanas, Ethel, and Streib, Gordon, eds., *Social Structure and the Family: Generational Relations,* Englewood Cliffs, N.J.: Prentice-Hall, 1965. pp. 10-46.

Gottesman, Leonard E. Milieu treatment of the aged in institution, *The Gerontologist.* Spring, 1973. pp. 23-26.

Gottesman, Leonard E. "Nursing Home Performance as Related to Resident Traits, Ownership, Size, and Source of Payment," Paper presented at the 100th Annual Meeting of the American Public Health Association, Atlantic City, New Jersey, November 15, 1972.

Harvey, Carol D., and Bahr, Howard M. Widowhood, morale and affiliation, *Journal of Marriage and the Family,* February, 1974. pp. 97-113.

Kahana, Eva. The humane treatment of old people in institutions, *The Gerontologist.* Autumn, 1973, Part I, pp. 282-289.

Kahn, R.L. Psychological aspects of aging. In: Rossman, I., ed., *Clinical Geriatrics.* Philadelphia: J.B. Lippincott, 1971.

Kalish, Richard A. *The Dependencies of Old People, Occasional Papers in Gerontology,* No. 6. Ann Arbor: Institute of Gerontology, 1969.

Kastenbaum, Rober, ed. *The International Journal of Aging and Human Development.* New York: Baywood Publishing Co., 1973.

Kent, S., Kastenbaum, R., and Sherwood, S., eds. *Research, Planning & Action for the Elderly.* New York: Behavioral Publications, 1972.

Kleemeier, R.W., ed. *Aging and Leisure.* New York: Oxford Press, 1961.

Kosberg, Jordan J. The nursing home: A social work paradox, *Social Work,* March, 1973. pp. 104-109.

Leeds, Morton, and Shore, Herbert. *Geriatric Institutional Management.* New York: G.P. Putnam's Sons, 1964.

Leichter, Hope, and Mitchell, Wm.E. *Kinship and Casework.* New York: Russell Sage, 1967.

Leik, Robert K. Instrumental and emotionality in family interaction, *Sociometry,* 26, No. 2, June, 1963, pp. 131-145.

Levinger, George. Task and social behavior in marriage. In: Bell, Norman W. and Vogel, Ezra P., eds., *A Modern Introduction to the Family.* New York: The Free Press, 1968. pp. 355-367.

Litwak, Eugene. Geographic mobility and extended family cohesion. *American Sociological Review,* XXV, June, 1960 a. pp. 385-94.

Litwak, Eugene. Occupational mobility and extended family cohesion. *American Sociological Review,* XXV. February, 1960 b. pp. 9-21.

Litwak, Eugene. Extended kin relations in an industrial democratic society. In: Shanas, E., and Streib, G. eds., *Social Structures and the Family Generational Relations.* Englewood Cliffs, N.J.: Prentice-Hall, 1965. pp. 90-326.

Litwak, Eugene, and Szelenyi, Ivan. Primary group structures and their functions: Kin, neighbors, and friends, *American Sociological Review,* XXXIV. August, 1969, pp. 465-481.

Maddox, George. Sociological perspectives in gerontological research. In: Kent, D., Kastenbaum, R., and Sherwood, S., eds. *Research Planning and Action for the Elderly: The Power and Potential of Social Science.* New York: Behavioral Publications, 1972. pp. 315-333.

Manaster, Al. The family group therapy program at Park Vie Home for the Aged. *Journal of the American Geriatrics Society,* Vol. 15, No. 3, March, 1967. pp. 302-306.

Milloy, Margaret. Casework with the older person and his family, *Social Casework,* October, 1964, pp. 450-455.

Moore, Wilbert E. Aging and the social system. In: McKinney, John C., and deVyner, Frank T., eds., *Aging and Social Policy.* New York: Appleton-Century-Crofts, 1966. pp. 23-41.

Neugarten, Bernice. The future and the young-old. *The Gerontologist,* February, 1975 (Supplement), pp. 4-9.

Neugarten, Bernice and associates. *Personality in Middle and Late Life: Empirical Studies.* New York: Atherton Press, 1964.

"Nursing Home Care in the United States: Failure in Public Policy." Washington, D.C.: Special Committee on Aging, United States Senate, Supporting Papers 1 and 2, 1974-75.

Reader, George G. Types of geriatric treatment, *The Gerontologist,* Autumn, 1973, Part I. pp. 290-294.

Rosen, Theodore. The significance of the family to the president's adjustment in a home for the aged, *Social Casework,* May, 1962. pp. 238-245.

Rosow, Irving. *Social Integration of the Aged.* New York: The Free Press, 1967.

Schorr, Alvin L. On selfish children and lonely parents, *The Public Interest,* Summer, 1966. pp. 8-11.

Schorr, Alvin. *Filial Responsibility in the Modern American Family.* Social Security Administration. Washington, D.C.: Superintendent of Documents, U.S. Government Printing Office, 1960.

Shanas, Ethel, and Streib, Gordon F., eds. *Social Structure and the Family: Generational Relations.* Englewood Cliffs, N.J.: Prentice-Hall, 1965.

Shanas, Ethel; Townsend, Peter; Nedderburn, Dorothy; Friis, Henning; Milhoj, Paul; and Stehouwer, Jan. *Old People in Three Industrial Societies.* New York: Atherton Press, 1968.

Simon, A., and Epstein, L.J., eds. *Aging in Modern Society.* Psychiatric Research Report No. 23 (February 1968). Washington, D.C.: American Psychiatric Association.

Simos, Bertha G. Adult children and their aging parents, *Social Work,* May, 1973. pp. 78-85.

Spark, G., and Brody, E. The aged are family members. In: Sager & Kaplan, *Progress in Group & Family Therapy,* New York: Brunner & Mazel, Inc. 1972. Also *Family Process,* June, 1970, p. 195.

Sternschein, Irving. The experience of separation – Individuation in infancy and its reverberations through the course of life: Maturity, senescence & sociological implications. *Journal of American Psychoanalytic Assoc.,* 21:3, 1973, p. 633.

Streib, Gordon. Older families and their troubles: Familial & social response. *Family Coordinator,* January, 1972.

Sussman, Marvin. Relationships of adult children with their parents in the United States. In: *Social Structure and the Family: Generational Relations.* Englewood Cliffs, N.J.: Prentice-Hall, 1965. pp. 62-93.

Sussman, Marvin, and Burchinal, Lee. Parental aid to married children: Implications for family functioning. *Marriage & Family Living,* XXV, November 1962. pp. 320-32.

Townsend, Peter. The effects of family structure on the likelihood of admission to an institution in old age: The application of a general theory. In: Shanas, Ethel, and Streib, Gordon, eds. *Social Structure and the Family*. Englewood Cliffs, N.J.: Prentice-Hall, 1965. pp. 163-188.

Weinberg, Jack. What do I say to my mother when I have nothing to say? *Geriatrics*, November, 1974. pp. 155-159.

PART II — Theoretical Bases for Practice

by Eugene Litwak, Ph.D.

This part outlines the theoretical bases for the uses of family kin (married children, siblings, and other relatives) in an institutional setting. These theories represent ideal forms of interaction which can be used as guidelines for planning and evaluating the course of action for staff of institutions for the aged.

Chapter 8. The Role of Formal Organizations and Staff in Maximizing Technical Knowledge

In order to understand the conditions under which family, kin, and other primary groups (such as friends, neighbors, resident groups) can be useful, it is best to understand why people feel that paid staff and formal organizations are thought to be effective. One of the best presenters of the idea of formal organizations as the most effective form of structure in an industrial society was Max Weber (1974). He pointed out that formal organizations were able to maximize technical knowledge. He assumed that any structure that could insure the maximization of technical knowledge would always be most effective.

Merit

Formal organizations are characterized by appointing, promoting, demoting, and firing people on the basis of merit. Merit is measured by formal training for the job or proven job experience and success. By contrast, families and primary groups are characterized by the fact that people are born into them and brought in on some relatively permanent bases with no thought they would be thrown out if they did not perform all of their tasks competently. Thus children are born into the family; one does not get rid of a child because he is not the best student. Spouses are brought into a marriage with the understanding they are to be spouses "until death do you part." If a spouse is not the best cook or not the most successful in his job, he/she is not thrown out of the marriage. Quite the contrary, the generalized expectation is that primary group members stick together under all conditions of adversity. To put the matter simply, a father is expected to leave his children whatever property he accumulates. He would be thought heartless if he left it to the child who did best in school even though this child was not related. He is operating under the nepotistic principle that the family relationship is a good *per se* rather than a merit principle. By contrast, a father who is head of a hospital is not expected to give his son a job in a hospital as a surgeon if in fact he is either not a surgeon or is an incompetent one. In refusing to hire his son, the father is using a merit criterion rather that a nepotistic one. Older people assessing a doctor use criteria of merit rather than nepotistic ones if they want to get good medical treatment. They will ask a surgeon who is a stranger rather than a son who is a psychiatrist to perform a major operation. A son who is a surgeon might decide not to operate on his father if he feels that a stranger is better or if he feels his nepotistic ties will cloud his technical judgments.

By its stress on merit the formal organization is better able than the primary group to insure that people with great technical knowledge are available to solve problems.

Specialization

Since the formal organization is generally much larger than the primary group, it allows for detailed specialization. This detailed specialization permits individuals to concentrate on a much narrower area of activity, and this concentration and the repetitive practice enable them

to become much more expert. Thus, doctors can concentrate on being surgeons and within that area concentrate on particular parts of the body. In contrast, the typical family, as a primary group, has two adults and multiple tasks or a generalized division of labor. There is a generalized division of labor between husband and wife, but within roles each has a multiplicity of tasks. Thus the wife might be the cook, the housecleaner, the chauffeur, the purchaser of food, the purchaser of clothes, the purchaser of nondurable household goods and consultant on durable goods, the chief link to household maintenance work (that is, she negotiates with plumbers, electricians), a lover, a teacher of moral values and religious beliefs, supervisor of educational achievement, consultant on recreational activities, a home nurse's aide, and first aid expert. A similarly long list can be made up for the husband. What must be considered is that, in a formal organization such as a home for the aged, each of these activities of the wife may be handled by a paid staff person who specializes only in that activity. If one person can spend a whole day concentrating on one of these activities (e.g., cook, chauffeur-bus driver, cleaner, janitor, food purchaser, electrician, plumber), he/she can be much more expert than the one who must handle all duties.

More generally, large scale formal organizations permit the kind of detail specializations which in turn lead to increase in technical knowledge of the specialist and as such gives the organizations a greater knowledge base than the primary group.

Coordination—Rules and Hierarchy

Weber points out that, to maintain the above kind of organizations with its large numbers and detailed division of labor, it is necessary to have some form of coordination other than that typically used by primary groups. Insuring that the right expert is at the right place at the right time requires a heavy use of written rules. In a small primary group with only two adults, there is no great need for written rules because the total group can be convened with little effort any time a decision has to be made.

Where one has a large staff, working at different times and geographically dispersed, it may be impossible to convene every time a decision has to be made. In giant organizations, like the postal service or General Electric Corporation with a labor force of several hundred thousand and spread over 100 cities, the mechanics of assembling the staff for a meeting are enormous and, once assembled, they find the problem of carrying on discussion equally insurmountable. If one took the staff of a nursing home which had 60-100 people working on different shifts, the problem would be horrendous. Nevertheless, coordination must take place; the nursing staff must coordinate activities with the medical staff, the cooks and kitchen staff must coordinate activities with the nursing and medical staff, the purchasing department must coordinate with the others, the social workers must be coordinated with all of them. Such coordination is often achieved through written rules that indicate the time of work, time of quitting, when certain activities, such as eating, making of beds, taking of temperatures, take place, the way records are to be maintained, or how equipment must be ordered. Rules can be written for those situations which will occur repeatedly or for which most contingencies can be anticipated.

The assumption is made that the bulk of coordination can be handled by such written rules. In effect, for a considerable part of their job actions, people do not have to relate to other people to coordinate but can relate to a written rule which in turn acts to coordinate their behavior. As a consequence, in most formal organizations it is a rare event for people in the organization to meet as a unit. By contrast, the primary group member can and does meet frequently as a total unit.

Putting the matter somewhat more modestly —if primary group members need to make a decision involving others in the group, they quickly call all members of the group together and inform them of the decision. It is the exception rather than the ordinary event when they look to written rules for guidance. Just the opposite tends to be true of members of formal organizations.

There are times in large organizations when written rules are not useful as guidelines for coordination because the events cannot be anticipated; therefore rules cannot be written to cover them. Formal organizations can handle these problems, if they are not frequent, by the simple expediency of assigning decisions to people higher up in the organization. They use hierarchy because the formal organization is still not in the position to call the entire group together. They cannot leave to each individual

the right to make a decision because there will be no coordination. The larger the organization, the longer the ladder of hierarchy. Though primary groups may have some concepts of hierarchy, that is, the mother or father may make a decision, this hierarchy has relatively short ladders of authority—two, maybe three, levels if the children are involved. By contrast, formal organizations may have as many as 20 different levels of authority. The person making the decision may still not be in close face-to-face contact with the group as a whole.

To summarize: The primary group relies for coordination on face-to-face contact of the whole group while the formal organization stresses the use of written rules and long ladders of hierarchy. Each group tends to stress opposite things.

Avoidance of the Intrusion of Personal Goals Over Organizational Ones

Thus far it has been suggested that formal organizations are better able to concentrate technical knowledge because they appoint people on such a basis, give them an opportunity to practice on limited problems, and have mechanisms for coordination so that the right expert is at the right spot at the right time. By contrast, the primary group does not appoint people on merit bases, and its mechanisms of coordination would not work even if they had great technical expertise.

But the formal organization faces yet another problem if it is to use its experts intelligently. It must prevent the individuals who staff the organization from introducing their own goals in such a way as to distort the organizational goals. Individuals introduce private goals by developing likes and dislikes for their colleagues or their clients in everyday work situations and, as a consequence, formulate goals on bases of their personal likes and dislikes. For instance, if a doctor were to either hate or love the person he is operating on, he might permit his feeling to interfere with his diagnosis without even realizing it. For this reason, many doctors do not treat their own families in serious medical situations. If a staff member is prejudiced against blacks, Jews, or Italians, for example, he might let his prejudice take precedence over demands of the job for service. On a more subtle basis, where staff people develop likes and dislikes for other staff members or clients which is personal (two staff people fall in love), they may not be in a position to evaluate the level of work of the other. To combat personal biases in the work situation, Weber stressed the need to develop impersonal relations. People should not express great feelings of emotion, either positive or negative, on the job.

By contrast, the family and other primary groups stress deep positive affect such as a parent's love for his child or the romantic love of one spouse for another. As a consequence, family members find it hard to judge each other objectively in terms of task performance. More accurately, family members ideally use as their first criteria love, affection, and preservation of their relationship. Objectivity and task effectiveness are secondary considerations. Thus, a family's evaluation of cooking would not give first priority to choosing a person to cook who is an expert, but would give first priority to what such a decision would mean to the mother and wife role and bonds of affectivity. Once that decision was made, the expertise in cooking would play a role.

Personal goals can displace organizational ones when people within the organization use their positions of power for their personal goals. Thus, if a staff member says he will not help out an aged client unless the family pays him extra money or unless the family purchases goods from a cousin who owns a shop, he is an individual taking advantage of his position of power in the organization to feather his own nest. Similarly, if a supervisor denies a promotion to a subordinate unless he buys things from the supervisor, there is a use of organizational position to achieve personal goals.

To prevent this kind of thing, the organization generally has rules which delimit the rights and duties of each individual. Since people in work relations should have strictly limited commitments, the organization may have rules against supervisors accepting gifts or money from employees. It may have rules against a supervisor using organizational resources to build a house or staff to run personal errands, e.g., drive his wife around, shop for food for his family. The duties and rights of the members of the staff are generally spelled out in great detail. But families and other primary groups have only generalized statements of rights and duties, and the commitment is relatively unlimited. A child belongs to its parents under many different situations; the exact specifications are not really clear.

In addition to the idea of *a priori* delimited rights and duties, the formal organization must have some appeals procedure which can be used by members to move around the staff in superior position. Sometimes this appeal procedure lies outside the organization. Thus, organizations which are accused of job discrimination may find the staff using a Human Relations Commission outside the organization as an appeal mechanism. Sometimes the appeal mechanism is within the organization, as, for example, the Inspector General's office in the Army. Finally, the formal organization tries to insure that individual goals will be used in a positive way in support of the organization by paying individuals with money – a generalized means for the achievement of most goals in our society. By payment in terms of money, the organization need not know anything about the employee's life outside the work situation and at the same time be somewhat assured that the organization has some incentive for the individual to do a good job. By contrast, the medium of exchange among family members is affectivity, commitment to "unlimited help," and a sense that the first priority will always be preservation of the relation. A mother does not have to be paid by a child for the services performed but performs the services out of love for the child with the idea of maintaining the relationship.

Separation of Policy and Administration – Dealing With Change

Because preservation of the relationship is an end in itself for the family member, primary groups generally try to internalize common values or policies within the family members. Otherwise they run the risk of dissension. By contrast, Weber points out, in formal organizations there is virtue in keeping policy and administration separate. He argues that such an arrangement preserves expertise through periods of major policy changes. He points out that, when the staff have internalized the values and policies of an organization, every time policy changes occur it is necessary to fire the staff or go through a process of resocialization. Both of these processes are costly where there is a big staff. For avoidance of these costs, he suggests separating policy from administration and having policy made at the top by a comparatively few number of people. When policy changes are made, one has only to change a few people at the top while the staff with all of its expertise remain. The model he suggests is represented by the Civil Service in the Federal Government. Thus, every time a new party takes over, with a new policy, it will fire the top eschelon job holders and replace them with people of its own while the bulk of the staff remains undisturbed.

Formal Organization Most Effective

With these thoughts in mind, we can see why Weber spoke about the effectiveness of formal organizations. He was speaking about organizations with the following structural characteristics: (a) appointment by merit, (b) detailed specialization, (c) written rules, (d) long ladders of hierarchy, (e) impersonal relations, (f) *a priori* delimitations of rights and duties, (g) separation of administration and policy. Such organizations are most effective because they concentrate technical knowledge, insure that the right knowledge is brought to bear at the right time on the right problem, prevent individuals from introducing extraneous personal values, and handle changes in policy without having to undergo expensive firing and hiring of staff or staff resocialization. He also feels the formal organizations are far better able to do these things than primary groups such as the family.

Definition of Primary Groups

In a formal definitional sense, a primary group is a group which has noninstrumental relations (relationship of group members is an end in itself), a face-to-face small group (the total membership can meet in face-to-face contact frequently), positive and deep affect, permanent relationships, and diffuse relations (no detailed specialization and unlimited commitment). In general, these dimensions of organizations are completely contrary to those of formal organizations, and, therefore it is understood why a formal organization maximizes technical knowledge while a primary group tends to minimize it.

Primary groups may, in fact, take on many different forms. They often appear in the nuclear family (husband, wife, and young children), among friends, neighbors, sometimes in Army platoons, sometimes among work groups, and sometimes among residents in homes for the aged.

Weber argued that the formal organizations are more effective than the primary group in general, but there are some goals for which the primary group is more effective (e.g., maintaining the primary group as an end in itself). However, he pointed out that, because of the antithetical structures of the primary group and the formal organizations, it is difficult for both forms of structure to appear in a strong form in any given society. Thus, a commitment to the achievement of most goals through use of technical knowledge means a tendency to weaken the primary groups and those few goals which they handle better than the formal organizations. In its most immediate application, this sense of inconsistency is experienced by staff as the need to keep families outside of institutions, since the more they play a role, the more nepotism or lack of professionalism they introduce. This same contradiction is reflected in families by their comments that the staff are cold and impersonal. It may be one of the elements that produces the sense of guilt and abandonment among kin and elderly when the elderly are placed in a home for the aged.

Chapter 9. Economies of Large Scale and Primary Groups

There is yet another view on the effectiveness of formal organizations vis-a-vis primary groups. It partly overlaps Weber's reasoning, but there are sufficient differences to warrant looking at it separately. This view is called "the economies of large scale." It suggests that, even where tasks do not require technical knowledge, large scale organizations may be more effective than primary groups because they can better coordinate manpower.

To make this point clear, let us assume that we have one spouse who is healthy watching another spouse who is ill and that the nature of the illness is such that the healthy spouse must be on watch 24 hours a day. Such a continuous watch would be enormously debilitating for the healthy individual, and it would not be long before he would have to give it up.

If we have three such cases and they all agree to cooperate so that one person will watch three sick individuals for 8 hours, then each healthy person will have to work only 8 hours. In other words, three people in one group can do better than three people as individuals. If one person watches 20 patients, we need only three people to carry on a 24-hour watch, leaving 17 people free to do other things. One person might be used to cook, one for maintenance, one for cleaning, several for raising money or working at outside jobs to support the home. The larger the staff become, the more necessary it is to have written rules to coordinate them, hierarchy to handle the situation not covered by rules, impersonal relations, *a priori* limits of rights and duties—all of the things Weber spoke about—without the assumptions of technical knowledge, but with the assumption that there is an advantage in grouping people into one organization.

However, such economies of large scale (such as three people watching 20 patients) can only be managed where the patients' lives can be routinized.

For instance, when one individual watches one patient, the individual can take the temperature whenever the patient awakens, he can serve him food whenever he is hungry, and he can arrange the diet to meet the individual taste of the patient. The room can be cleaned when it suits the convenience of the patient. However, when one person is taking care of 20 patients, he forces the patients into a common routine. The ability of staff to care for 20 people is gained at a cost to the resident; that is, all residents must awaken at the same time—they cannot sleep and awaken when they want. Similarly, one person can cook for 20 people without much extra effort if he can cook one meal for all of them and if they eat at the same time and same place. However, if separate meals must be cooked for each person and each person wants to eat at his own time and place, it might take 20 times as long to cook meals. In all areas of life, the same logic suggests a move toward economies of large scale (that is, each individual staff handles a large number of patients); generally for the clients there is a loss of choice or discretion. This loss is presumably compensated for by the fact that the client will have basic needs met which he would not if he had to rely on small primary groups.

This concept of economies of large scale, like the argument for maximizing technical knowledge, assumes that the formal organization is more effective than the primary group. At the same time, it suggests that economies of large scale have a price and that that price involves the routinization of tasks. In other words, the efficiencies of economies of large scale are bought at the costs of eliminating idiosyncratic services. Whether this price is high or low depends on how much value is attached to the more idiosyncratic aspects of a given task, or, alternatively, whether the idiosyncratic aspects of the task can be handled by other groups while economies of large scale are handled by formal organizations.

Chapter 10. Alternative Theories of Relationship Between Formal Organizations and Primary Groups

Given the above analysis, there are three alternative theories of the relationship between formal organizations and community groups.

Formal Organizations Required

One theory, implied in the works of Weber, states that the only type of organization required in an industrial democratic society is the formal organization. Primary groups, like families, are an anomaly in modern society. All activities are optimally handled by formal organizations. Medical treatments are handled by doctors and hospitals. Protection is best handled by police. Mental health problems and tension management are best handled by professional therapists, social work agencies, treatment homes, and mental hospitals. Preparation of food is best handled by restaurants and the food industry.

According to this theory, the ideal set up for older people resembles a fairly luxurious hotel with a complete set of services provided by the staff from medical to household, to leisure, religious, etc. There would be no great need for the staff to really deal with the families at all; homes for the aged would follow a policy of excluding relatives.

Formal Organizations and the Isolated Nuclear Family Required

A second alternative theory suggested by Parsons (1959, 1968) states that formal organizations and one type of primary group—the isolated nuclear family—are required. The isolated nuclear family consists of husband, wife, and young children. The isolated nuclear family is required because there are three functions necessary for survival of society, functions which can only be managed by primary groups. These primary group functions are socialization (infant care during the first year), management of tensions, and procreation. Of these three functions, tension management may be crucial for the older person who has neither young children nor the desire to procreate. Parsons acknowledges that Weber was correct in assuming that the bureaucracy and the primary groups had antithetical structures; they must be kept at great social distance from each other lest their atmospheres corrupt each other (that is, the family introduces nepotism into the bureaucracy or the formal organizations introduce contractual and instrumental relations into the family).

The physical isolation of the two units is accomplished by the structure of the isolated nuclear family, the key structural feature being that only one person, the husband, has a major commitment to the labor force. With only one person in the labor force it is hard to introduce nepotism into the work force and invidious occupational competition or contractualism into the family. In addition, the fact that only one person is in the labor force makes it much easier to move individuals around to different geographical areas in order to rationalize the distribution of labor and that the best man is sent to the best job. One person in the labor force means the wife's major commitment is to the home; after children enter the labor force meaningful exchanges are broken off as it is for siblings and other relatives. Hence the adjective "isolated" is used to describe the family.

This formulation suggests that, as much as possible, people be kept in natural nuclear family units and kept out of homes for the aged. If the goals of tension management are to be maintained where the nuclear unit is weak, it may be necessary to use aggressive outreach services, such as homemaker services and visiting nurses services, to maintain the nuclear unit as much as possible. Where death, divorce, or lack of prior marriages produce a single person, the policy suggests that society must encourage remarriage or marriage as quickly as possible. Instead, society's social security legislation currently discourages remarriage. Parsons' position suggests legislation which provides an incentive for remarriage.

When severe weakness requires 24-hour care, the Parsonian formulation suggests that nuclear families should be kept intact as much as possible and some kind of motel-type arrangement be

developed in homes for the aged. When death prevents the nuclear family's existence as a unit, his theory suggests some foster-spouse arrangement or some functional equivalent to the lost spouse. Among older people special "friend" relations may be involved.

What is being sought is the functional equivalent of a living unit of two people which is relatively permanent, affective, face-to-face, noninstrumental, and diffused. Central in this formulation is the use of homes for the aged as little as possible; the only kin the aged should relate to is a spouse or a spouse substitute, and all other kin should be discouraged from visiting the home.

The empirical world shows, contrary to both Weber's and Parsons' formulation, that often bureaucracies operate most effectively when they work closely with primary groups. The Army often seems to fight better when it has primary-like groups at the platoon level as well as formal organizations for supplies and equipment (Shills 1951; Shills and Janowitz 1954). There are times when formal organizations increase their productivity when they have primary group structures in support (Whyte 1961). There are governmental bureaucracies which at times work better when they have peer groups which involve some degree of trust (Blau 1955). Hamburg (1957) suggests that mental hospital wards sometimes do best when they work closely with patient groups in a more primary group setting. Coleman and his associates suggest that the educational bureaucracies are most likely to aid children in reading when they have families who provide positive inputs (1966). The idea that the formal organizations might on occasion do better when closely linked to primary groups is antithetical to both Weber's and Parsons' positions. In addition, it can be argued that those attributes sought to be the exclusive province of the primary group, such as tension management, procreation, and early socialization, also seem to operate in a partnership arrangement with the formal organizations. Extreme forms of tension are the same as mental ill health; and many would say that the therapeutic professions and the various institutions, like social work agencies, treatment homes, and, mental health hospitals, aid in the treatment. The early socialization of the child is handled by a woman in partnership with various books on childrearing (such as Dr. Spock, the pediatrician) and various manufacturers of leisure-time toys. Procreation is handled by the family in partnership with various manufacturers of contraceptives, doctors dealing in sterility, medical experts, and therapeutic experts on impotence.

In other words, primary groups seem to operate effectively in all areas of life—not just those of early tension management, procreation, and early socialization. And formal organizations operate effectively in the latter areas. Finally, the evidence suggests that primary groups, other than the isolated nuclear family, seem to be necessary for task achievement. For a full detailed discussion of the problems with this approach, see Litwak and Figueira (1968) and Litwak and Meyer (1974). But these problems are the empirical reasons for the rejection of both Parsons' and Weber's formulations.

The theory advocated in this manual is one of shared functions and balanced coordination. To understand this theory it is important to go back to the Weberian and Parsonian formulations which suggest that the formal organization is best able to maximize technical knowledge. If primary groups are still essential, what are the conditions under which technical knowledge is not important for solving problems? Technical knowledge means all knowledge which requires training above and beyond that of everyday socialization. There are degrees of technical knowledge. A doctor needs almost 8 years of training beyond high school to handle his tasks, an extreme of technical knowledge. Most people can learn to dress themselves, speak an everyday language, cook, shop, drive a car, go to movies, operate the television set, operate home washers and dryers, through everyday socialization—the other extreme of nontechnical knowledge. In between are degrees of technical knowledge, such as 2 weeks, 2 months, 6 months, 2 years, of training above and beyond everyday socialization.

The theory of shared functions suggests that there are many times when technical knowledge is not crucial for action because it cannot be brought to bear in time to make a difference. In such cases, speed, flexibility, and commitment to people may be more crucial for handling tasks. People with everyday knowledge who have immediate access to each other, who have wide-ranging commitments, and who are devoted to each other may be more effective than those with only technical knowledge.

243-962 O - 77 - 7

Unpredictable Events

There are many times when events are so unpredictable that experts cannot be brought to the scene of action in time to be effective. For instance, a man who is hit by a car and has had an artery cut may bleed to death before a doctor gets to him. A person walking the streets may be attacked by a mugger and robbed before a policeman comes to his aid. A person knocked unconscious in a burning building during a major tornado might be burned to death before the fireman rescues him. A person sitting alone in his room, whose mind has collapsed, may starve to death before he comes to the attention of a doctor. These are all events where the professional might be of no use to the individual who needs help because the situations are so unpredictable that there is no way of insuring that the expert will get to the scene. In all of these cases, an ordinary individual with the knowledge learned through everyday socialization can be of enormous aid if he is in close personal contact with the individual, has unlimited commitments, and noninstrumental relations. Such an individual can apply first aid, call the police, or physically aid a person being mugged. He can drag a person out of a building or call a hospital to pick up an individual in a catatonic state. People with strong primary group ties are very likely to get the kind of help needed in such situations. The expert might do a better job if he got to the scene, but the ordinary person has enough knowledge to do some kind of job. It is crucial that someone who cares is at the scene of action very quickly. Thus, primary groups may be more effective than formal organizations for dealing with extremely unpredictable events.

Contingencies. Sometimes experts cannot be brought in because the number of contingencies are too great and their relationship to each other too uncertain to permit either the training of specialists or proper coordination. Goldberg (1967) reports that agencies' efforts to provide proper home management for poor people through visiting homemakers eventually had to turn from the use of professionally trained home economists to the use of indigenous people who had successfully managed their households. The agency found that there were too many contingencies involved in the purchasing of food in very poor neighborhoods, and the pricing of foods, for which home economists were trained, was only a limited aspect of the problem. Purchasing food in a poor neighborhood not only involved a knowledge of the prices in various stores but an understanding of which stores would provide credit if money were low, and how to persuade storekeepers to give credit (where persuasion might involve an intimate friendship or perhaps lies). At the same time it was necessary to take into account the food tastes of people in the strata which might be different from those of the middle-class home economist, the problem of transportation—if one store is cheaper but farther away and one cannot leave the house for long periods because sick people are at home, or the fear of robbers, or the condition of people too weak to manage large shopping. In addition, shopping may require some knowledge of the streets to avoid, such as blocks where drug addicts and muggers are likely to be located. The home economist who is trained in comparison shopping and the advantages in buying during sales and in bulk may find that many of these contingencies are not within the scope of her training. If experts were used to cover all contingencies when purchasing food in a poor neighborhood, one would need: a home economist, a public relations counselor, a visiting nurse, a childrearing expert, a local policeman, an anthropologist, a drug counselor, a youth worker. The problem is visible with troubled multiproblem families which may have as many as 10 agencies working with one family. The ordinary family in the poor areas, as well as middle-class families, has many situations which involve the same number of contingencies as multiproblem families, but the problems tend to be not as serious, therefore do not require public welfare services, and as a consequence, are not publicly visible. In situations where there is a multiplicity of contingencies, experts often are unavailable because they are either not trained or there are too many to coordinate. In such situations the ordinary primary group member who has successfully handled the problem might be able to give better advice than that of a professional with limited services—and limited knowledge.

Economies of Small Scale. Just as there are economies of large scale, there are also economies of small scale. Economies of small scale mean that science and technology often reduce the cost and complexity of events so that the ordinary family can manage the event as well as the expert. For instance, driving a car for transportation was originally the job of an expert

and now it is one for the nonexpert. Laundry, recently handled by large formal organizations, has been largely replaced by the home washing machine. The machine is manufactured at a low cost so that the ordinary family can afford it, and the instructions are so simplified that the average family can run it. There is some movement in medicine for simplifying some lab tests so that the ordinary individual can perform them at home e.g., certain diabetes tests can be taken at home. The whole do-it-yourself movement is of this kind. More important, any task now handled by large formal organizations and needing trained experts can in principle be reduced in cost and simplified by future invention so that the ordinary family will be able to handle it. The hand computer has recently undergone a technological revolution, there is reason to assume it might happen as well to the large computers, airplanes, clothing manufacture, police protection, Army warfare, etc. (Litwak and Figueira 1968).

Where economies of small scale provide the family with resources which equal that of formal organization, the primary group is a faster and more flexible unit of action. For instance, in contrast to laundry service, a home washing machine permits the family to wash clothes when it wants and in response to immediate emergencies.

Families Are Effective Structures for Handling Nontechnical Events

More generally, there are some very substantial aspects of life where the family has resources which match those of the formal organization. These occur in unpredictable situations because the experts cannot be brought to the situation in time to make a difference, in situations where there are many contingencies because experts cannot be trained or coordinated, in situations where science and technology provide economies of small scale, and in frontier areas where no expertise has been developed. Henceforth, the tasks which must be handled in such situations will be referred to as nontechnical tasks. Such tasks arise in almost all areas of life; they are closely associated with technical tasks, and the primary groups are better able to handle them because their resources are equal to those of formal organizations. Their structure under such circumstances permits a faster, more flexible, and more committed decisionmaking process.

The primary group's small, face-to-face contact means shorter lines of communication. Acceptance of noninstrumental relations leads to its members performing tasks even when they cannot be rewarded. And its stress on diffused relations means that it is less likely to be upset by unexpected events or many contingencies.

In principle the primary group is a faster and more effective group for handling events which do not require technical knowledge because it has shorter lines of communication, it provides greater legitimation for handling idiosyncratic events, and people are willing to act even when complexity makes it difficult to reward them on merit. The formal organization can more than compensate for its longer lines of communication and rigidities of task and job definition if it can use its technical knowledge.

Consider what would happen if one had to go to a doctor for a tension headache, call a policeman every time a young child wandered into the street, wait for a doctor and ambulance to come by every time an elderly person collapsed in the street, leave the entire matter of reporting a mugging to the police, or identify the muggers to the police. The individual would suffer enormously—unrelieved headaches, children killed, elderly people wasting away on the streets, muggers seldom if ever caught. Alternatively, it would be necessary to build up the professional staffs so much so as to bankrupt all other services or to have professionals drop all forms of their activities and concentrate on one aspect, e.g., doctors deal only with headaches and no other forms of sickness.

Shared Functions and Homes for Aged

The general theoretical point being made is that primary groups are most effective for dealing with nontechnical tasks, and formal organizations are more effective for dealing with nontechnical tasks associated with them. Therefore most goals require some combination of primary groups and bureaucracies to achieve maximum effectiveness. Every area, no matter how well explored, always has frontier areas where there are aspects which are unpredictable or have too many contingencies to be easily handled by the state of technical knowledge. Furthermore, Litwak and Figueira (1968) argue that science and technology have an equal probability of producing economies of small scale and, as a consequence, introducing the primary groups in

some aspects of every goal. This kind of explanation is certainly consistent with the empirical findings that primary groups and formal organizations in close contact are often associated with more effectiveness in all areas of life, e.g., the Army, business, large governmental agencies, educational institutions, and hospitals.

Let us examine the problem as it bears on homes for the aged. There are generally two reasons why people are brought into homes for the aged. Either medical demands which are technical in character require 24-hour observation or the resources of the nuclear family are so depleted by illness that ordinary family tasks can no longer be accomplished and some economies of large scale are necessary to insure that the client has proper food, clothing, and shelter.

Either of these reasons does not obviate the need for dealing with nonuniform events and therefore the need for primary groups. The aged still have idiosyncratic food needs, leisure needs, clothing needs, household furnishing needs, laundry needs, medical needs, or tension management needs. Organizations which are set up to handle problems of technical knowledge or large scale resources are specifically not set up to handle nonuniform events. They can only function effectively when the events are routinized (made more predictable and the number of contingencies are reduced to the point where technological knowledge applies or economies of large scale can be used).

From this reasoning it can be argued that the staff, in the homes for the aged, will be under a job-imperative to make all nontechnical tasks as uniform as possible.

The fact that in many hospitals patients are awakened at 5:30 in the morning has to do with the need for the night staff to take all temperatures and have them recorded before the day staff take over. The fact that in some nursing homes patients are all put to bed in the early evening (sometimes as early as 6:30 p.m.) has to do with the day staff's efforts to get the patients settled before the evening staff take over. In the past, patients in medical facilities were put on beds which were very high to make it easier for hospital staff to change the linens and doctors to examine the patient. The pressure for staff to rationalize their time took precedence over the patients idiosyncratic needs.

There are indeed nonuniform events in homes for the aged and nursing home facilities, and there is an intrinsic conflict between the needs of the staff to achieve economies of scale and to utilize technical expertise, and the clients need to have their nonuniform tasks handled expeditiously. To maximize the nonuniform aspects of his stay in such homes, a patient needs some primary-like group to aid him. If in addition to the standardized food the patient would like some food which fits his own personal idiosyncratic experience, he needs some primary group to provide it. If the patient wants some idiosyncratic form of recreation, some personalized clothing, some personalized room effects, some personalized and idiosyncratic tension management, some quick handling of the nonuniform aspects of medicine, then he will do best if he has some primary group at his beck and call.

Furthermore, there will always be cases where the staffs interest in saving time and energy go directly counter to the patient's need for idiosyncratic care. This conflict is of special concern in nursing homes where the patients are very old and unable to defend their idiosyncratic interests, either because they are physically and mentally ill or because they are defeated by the fact of being old in a society which tends to define older people as "useless." Residents in nursing homes need primary group members to provide supplemental services, to be their advocates in the nontechnical areas of life.

The conflict of interests between staff and patients represents legitimate and important interests of both parties. In such conflicts there is no concept of one side completely winning or losing because the client needs both the technical expertise of the staff and the nontechnical help of the primary group. It is therefore a conflict which can never be resolved but which must be continually negotiated.

Such "legitimate" conflicts are intrinsic to society in general and in all areas of life, not just in the nursing homes. For instance, unions represent their memberships needs for a higher wage as opposed to the managerial demands to maximize profit. Since both high states of profits and high wages are in the short run often in conflict, there is often no way both can be raised simultaneously. In the larger society, conflicts between the need for public safety and freedom of speech also involve areas of legitimated conflict with the police representing one goal and the newspapers another and a continuous bargaining taking place between them with the courts as arbitrators. Where the police have both functions (that is, censorship is a function of police),

freedom of speech tends to suffer. Where the press tends to dominate, the police role suffers. The idea of legitimate conflict where the society has two or more goals which it requires but which are not necessarily in complete agreement is a widespread one. Therefore, when it is pointed out that the staff and the clients are in a state of partial conflict over the simultaneous attempt to develop both economies of large scale and small scale, and the handling of technical and nontechnical tasks, we are not saying anything which is unique to the problems of nursing homes.

Having stated the theoretical bases for this conflict, it is necessary to quickly point out that often the introduction of the family into the homes for the aged is experienced by the staff as offering an immediate short-term relief. By taking over many of the nontechnical tasks, such as aid in feeding, dressing, giving of nondangerous medication, aiding in recreation, relatives can give the staff immediate freedom to deal with the technical areas of their job.

Balance Theory of Coordination

However, such relief takes place within a larger context of a continuous conflict between formal organizations and primary groups. Generally the same group of people should not try to handle both needs. Just as it is a conflict of interest if a union leader is also an owner, a manager of a large concern is also the owner of a supplier of that concern, a Government official is also an employee of a firm seeking a Government contract, a lawyer seeks to represent two contending parties in a legal action, it is also a conflict of interest if the same staff seeks responsibility for both the technical and nontechnical parts of the job or if the primary groups seek responsibility for handling the technical as well as the nontechnical parts of the job. Even the best of staff with the best of motivation may not be able to put themselves continuously in the place of the clients and might therefore systematically overlook the nontechnical tasks, especially in situations where clients are older people in a nursing home who are too frail to make their needs known in a forceful manner. Dealing with such nontechnical problems requires people who are intimately related to the clients and who, as a matter of work pressures, will look to the economies of large scale.

This is not to say that the staff should be dominated by the primary groups. The effects of such domination can be equally disastrous for the delivery of technical services. Thus, in homes for the aged dominated by a policy board of lay people who have relatives who are residents in the home, technical services may be delivered on a nepotistic basis so that those who are friends or relatives of the board get too much medical attention while others are left unattended. Doctors and staff who offend the residents whose family are board members may be fired, leading to nepotistic criteria for professional activity. Economies of large scale are sacrificed, and the delivery of technical knowledge to all residents is also sacrificed.

In summary, there is a great need for primary groups and formal organizations both to be present and to closely coordinate their activities if the resident is to maximize his goal achievement, that is, meet both the technical needs and the nontechnical needs of the residents. If the staff provide the technical medical care, the primary groups may best apply the nontechnical aspects of medical care, e.g., take care of certain idiosyncratic creature comforts, help the sick client who wants water, help a client who can't move to turn over, aid the patient in going to the toilet, insure that the patient eats the food by psychologically encouraging him and even spoonfeeding him, changing dressings that require no technical skills for application but which lead to patient discomfort when they are not changed. If the staff provide the standardized food, the relatives can supplement the nonstandardized fare through special food treats because they often have the best knowledge of the idiosyncratic food tastes of the resident as well as knowledge of how to prepare the food (Dobrof 1974). If staff provide standard forms of protection, primary group members such as the family are often in the best position to guard against idiosyncratic staff abuse; they are often the only ones residents will trust to tell about being hit by the staff. They are often the only ones outside of the staff member involved to see the physical signs of abuse (such as a bruise) and who will at the same time push an inquiry as to how the bruise occurred.

Such primary group members are also the ones who are most likely to know about the prize possessions of the residents and to note if any of them are missing. Once such information is fed to the staff, they are in a position to carry

out the technical aspects of the investigation. Such primary group members are also most likely to know the kinds of home furnishing and leisure-time activities of a nontechnical sort which please the clients. They are often in the best position to provide extra money which permits idiosyncratic furnishing of rooms; they take the resident out to various movies or concerts or to purchase books and engage in various discussions. All this supplements the staff's more standardized furnishing and entertainment fare. For a development of these points and some empirical evidence, see Dobrof (1974). Furthermore, such primary group members, because of their enormous concern for the resident, are willing to take the time and give their energy to provide for idiosyncratic needs, even when no one can observe their refusal to do these things.

To produce maximum medical care, maximum enjoyment of food, maximum protection against abuse, maximum psychological health, maximum leisure pursuits, the formal organization and the primary groups must coordinate their activities. However, at the same time the two groups often have antithetical structures which if brought into close contact lead to conflicts that in turn reduce either the technical tasks or the nontechnical tasks.

The linkage between the formal organization and the primary group must be close enough to permit coordination but not so close as to cause their contradictory structures to negatively influence each other. The balance theory of coordination suggests that there is a middle point in social distance between formal organizations and primary groups where they are close enough to coordinate technical and nontechnical tasks, while distant enough to prevent the structures of the two groups from clashing. This middle point is considered to be the point of balance between the two contradictory demands.

This concept of balance has several important implications which differentiate this theory from that of Weber or Parsons suggested above. It suggests that at any time formal organization and primary groups may either be too close or too distant, while the prior theories only spoke about the problem of being too close. In terms of practice, there may be times that institutions have to use aggressive outreach programs to bring significant primary groups into action, while at other times they may have to have procedures for moving some primary groups out in order to maintain proper distance.

The Concept of Social Distance and Family Types

Nuclear Family. The policy implications, with regard to nuclear family structures, are along some of the same lines suggested by Parsons—wherever possible, the nuclear family should be kept intact because it is often the best source of handling nontechnical tasks. Like Parsons formulations, the policy implications suggest building up the nuclear family members where possible and urging remarriages where death or divorce produces single families. Where family members are disabled or can't remarry, aggressive outreach programs should seek to maintain the nuclear family as much as possible, e.g., meals on wheels, visiting nurses, visiting homemakers' services.

Where medical reasons require 24-hour constant care, wherever possible the institution should be set up for permitting primary group living arrangements, e.g., motel type of arrangements with cooking and eating facilities for each resident. If that is no longer possible, the home should be structured so that at least one part of it has a human relations structure with strong resident's control while the other part is handled by staff with both parts sufficiently isolated administratively in order to continue despite differences in structure.

This formulation differs significantly from Parsons' in that it envisions role relations between men and women to be different (Litwak and Figueira 1968), and other primary groups, such as kinship groups, neighborhood or residents groups, and friendship groups, play significant roles. The institutions must not only be concerned with primary groups, such as the nuclear family, but with such groups as the larger kinship system as well.

We are therefore advocating two major policies which differ from Weber and Parsons. One, the linkages must include distance-closing as well as distance-opening procedures. Second, primary groups other than the nuclear family must be involved. These points, once elaborated, provide the staff with basic guidelines on how to proceed with both nuclear families, kin, friends, and resident primary groups. However, in this manual we deal only with the kinship system.

The Kinship as a Primary Group. The kinship unit (adult children, siblings, and other relatives) is an especially important type of primary group for older people in homes for the aged. Such people are often without a spouse and have fellow residents and friends who are often too fragile themselves to provide much in the way of exchange.

What kinds of kinship systems are viable in modern society? Parsons thought there would be no kinship system which was viable because a modern industrial society requires differential mobility since it is hard to maintain kinship ties over geographical distances. Modern industrial systems require differential occupational mobility based on merit. Traditional kinship ties encouraged nepotism since, having more than one family member in the labor force, there is an incentive to help. Litwak (1960a, 1960b) pointed out that kinship systems can survive despite geographical distance and class difference in modern societies because modern technologies of communication and a money economy mean services can be transmitted across large distances very quickly. Furthermore, by differentiating between technical tasks and nontechnical tasks, kinship units can be socialized to stay out of the uniform areas of exchange. Various mechanisms are created to keep kinship units isolated from the occupational world so as not to introduce norms of nepotism into the formal organizations. Thus, through the processes of role segregation, the average individual in American society sees nothing wrong with applying norms of merit in the work situation and norms of nepotism in the family situation.

How do family members provide for differential occupational mobility and yet retain contact over class differences? Class differences are often not large and often reflect differences in the division of spoils rather than value and language differences, which might prevent exchanges. Insofar as difference in language and values does exist, mobile individuals have multiple class-language skills. The second generation immigrant can often communicate with the first generation even though the latter has limited English language skills because the second generation retains some of the language skills of his parents in addition to learning English. In the same way, people who move from one class to another might still retain the language skills of past class position which may be sufficient to permit communication.

Kinship systems in a modern society must communicate across class differences and geographical distances as well as restrict themselves to aid in the nontechnical areas of life while leaving the technical ones to formal organizations. Such basic economic tasks as income, housing, medical care, police protection, etc., are managed by large formal organizations, and kinship groups should only handle the nonuniform aspects of these areas (e.g., home nursing, first aid, preventive diagnosis, temporary small supplemental loan, reporting crimes, walking or driving people home to insure safety). In other words, the modern kinship system differs from the past in that it is a web of semi-autonomous units that exchange in some areas but are completely autonomous in others. These units contrast sharply with the traditional extended family kin group in which there were one head, one household, and one economic unit. The new kin system is called a Modified Extended Family.

Thus far the model of kinship points up how exchange can take place despite the barriers of the occupational world. However, to maintain the confederation of semi-autonomous nuclear units, it is necessary to speak not only of exchange but of procedures which will insure that the nuclear families do not merge as a consequence of such exchange. A merged kin unit would not permit differential mobility and would lead to nepotism (Litwak 1965).

One mechanism to avoid exchange leading to nepotism is the socialization of people to insure that exchanges are symmetrical. One family member cannot take advantage of another if the other repays as much as he is given. However, reciprocity can be defined in terms of both time and type of exchange given. On one extreme, one family loans another a small sum during one period of illness and the other quickly reciprocates when the prior giver becomes sick and in need of temporary help. However, often the exchange cannot be in kind. For instance, many people have a desire for immortality; they feel that their future will be maintained if their grandchildren remember them. For such people economic gifts are reciprocal if, in turn, they have an opportunity to see their grandchildren dressed better or having better furniture, etc. Symmetry can be defined along a time dimension. People may give gifts to young married couples in anticipation that the couples will help them when they be-

come old. The sense of guilt many children have when their parent is put in a home for the aged is often testimony to the power of symmetry along a time dimension.

Yet another way of insuring the nuclear family autonomy, despite asymmetry in exchange, is bestowing gifts on institutional occasions. On occasions, such as birthdays, weddings, graduations, new jobs, new houses, there is often a social mandate that gifts should be given. Where society mandates a gift, the receiver is often not obligated to the gift givers. Many people who seek to provide services but are afraid to endanger the autonomy of the kin unit provide gifts on institutional occasions.

A society which encourages multilinear ties insures many different sources of kinship aid from parents, parents-in-law, siblings. It provides any given nuclear unit with an escape hatch from another which demands mergers as a price for exchange. If a young wife has parents who demand that she and her husband turn down a job offered in another town as the price of aid, the couple can turn to the husband's family or to a married sibling for help. In addition, the nuclear family's uniform tasks being maintained by formal organizations and not controlled by the kin provide the nuclear unit in question some degree of autonomy. When social security began, it gave the older person much more autonomy for resisting demands of the younger kin. Finally, the kin's geographical distance from each other makes it hard to enforce merger. From such considerations the ideal of the modified extended family as a series of semi-autonomous nuclear units arises.

Staff can categorize the kin who confront them into several logical types. Typically there are many kin who recognize the need for autonomy but not exchange. The nuclear family is viewed as ideal. Staff see all kinship exchange leading to nepotism or infringing on the liberty and autonomy of the individual. For such people, the staff have to point out that there is a series of services the kinship unit can provide for elderly people in homes for the aged or nursing homes—extras in food, home furnishing, medical care, supervision of staff to insure they are doing their job properly, entertainment, clothing, tension management. These extras do not lead to kinship mergers or interference with technical tasks. Such kin might also have to be taught to communicate across geographical distance and class differences. Finally, they must be shown the various mechanisms of exchange, e.g., symmetry, institutional giving, that permit exchange to take place with minimal loss of nuclear family autonomy.

Another logical type of kin relation is illustrated by some elderly and their relatives who tend to have a traditional extended family view and feel that the nuclear family should take the elderly into its household rather than put them into a home for the aged. Here a problem arises because the kin or the elderly do not see the need for the nuclear unit to have any autonomy. They do not see that a merged system does not permit a rational distribution of labor and leads to nepotism in industry. For such elderly and kin the staff must work especially hard on developing the mechanism for maintaining distance despite exchanges, e.g., symmetry of exchanges in time and in kind, the use of institutional occasions for gift giving, the use of multiple sources of kinship aid, stress on organizational bases of aid which provide some autonomy, and the fact that geographic distance prevents close participation in several significant areas of life. This type of elderly and kin often does not recognize the legitimate functions of formal organizations and may try to introduce nepotistic consideration into the staff relations, e.g., insist on special treatment for their relatives at the expense of others. The staff may, as a consequence, use linkages that keep the kin at some distance by limiting their visiting hours or having rules against tipping staff.

Of course, the elderly and their kin may have entirely different concepts of the ideal relations. The elderly may have a traditional extended kinship relationship in mind and their kin may see the autonomous nuclear family as ideal. It could, of course, be the other way around as well, leaving the staff in the position of having to stress different things to different elements of the kinship system.

This, of course, all assumes that the staff has the proper appreciation that the kinship unit can play an important role in handling the nonuniform events. In fact, the staff, like the family, may not recognize the legitimacy of kinship units and might as a consequence seek to discourage all kinship contacts by restricting visiting hours, not providing parking facilities, not providing ready telephone access, not aiding residents seeking to write letters, having rules which outlaw nonuniform exchanges, such as rules against kin bringing food treats, having

extra furnishing in their rooms, taking clients out of the home.

A staff may also err by involving the family too much, disrupting the autonomy of the nuclear units or producing nepotistic criteria in the more uniform areas of life so that certain residents get preferential treatment in medical care, room assignment, selection of foods (which in fact will be prepared for all but only reflect the desires of a few), using residents' recreational facilities, being given the best furniture. There are several ways this type of error occurs; the staff, recognizing the loss of primary group ties for elderly who are moved into an institutional setting, take on the nontechnical family functions as well as the technical ones. In effect, a staff person becomes like a family member to one of the residents. Without realizing the fundamental conflict in such a dual role, staff members may slowly but imperceptibly see nepotic criteria replace merit in technical areas as well as nontechnical. As a consequence, such homes for the aged may have much poorer technical services and constant internal complaints of favoritism and nepotism. Perhaps more obvious are nepotic ties which arise around the rich residents or their kin. In this case, a general administrative style does not encourage staff to be familistic, but rather a few rich families exercise power over the staff via the lay governing board or by direct money gifts to the staff. This produces staff action in the technical areas that are not guided by merit but nepotism, e.g., the rich get medical attention even for trivial nontechnical problems while the poor do not get medical treatment for serious problems.

Staff may err in either direction of not permitting nontechnical tasks to be handled by the kin or using nepotistic norms to govern technical tasks, that is, letting kin relations dominate the technical and nontechnical tasks. Either solution is ineffective. It is very important for administrators and staff to recognize the difference between nontechnical tasks and technical ones and the need to have different organizational structures for each (Litwak and Meyer 1974).

At this point, a brief summary of the argument is necessary. Three theoretical positions of staff and kin relations have been developed. The Weberian position stresses the fact that the staff have little, if any, relationships with kin and that technical expertise and economies of large scale solve all problems of the elderly. The Parsonian position says that Weber is right with the exception of such tasks as tension management which must be handled by the isolated nuclear family (that is, the spouse of the aged). The staff should, at most, seek functional substitutes for a missing spouse, or if the spouse is present, the staff should accommodate the nuclear family but otherwise have nothing to do with kin. This position stresses that all other activities, food, recreation, medicine, are technical tasks or involve economies of large scale and should be handled by the staff. Distance from the nuclear family should be as great as possible, and staff relationships with the kin should ideally be nonexistent. The third position is called a theory of Shared Functions and Balanced Coordination; it states that the formal organization and the staff are best able to handle technical tasks and economies of large scale but that the primary group is best able to handle the nontechnical tasks and the economies of small scale. Both types of tasks are very important and remain with society for the foreseeable future. However, since primary groups and formal organizations do have antithetical structures, it is necessary for staff and primary groups to continuously evaluate their relationships so that they remain in balance; that is, they are close enough to coordinate the technical and nontechnical tasks but still have sufficient distance to avoid conflict between their structures.

The policy implications for this latter position are much more complex than for the Weberian or the Parsonian position. This latter position requires the involvement of primary groups in the nontechnical aspects of almost all areas of activities in the elderly, medicine, food, recreation, religion, tension management, physical protection. At the same time, the staff must always be careful not to let this involvement overwhelm the staff's capacity to manage the technical tasks. Alternatively the kin must insure that the staff's involvement in technical tasks does not overwhelm the kinship's ability to handle the nontechnical ones. There is continuous tension between the two systems, and, therefore, there is continual motivation for members of either system to seek to suppress the other.

In addition, the shared function approach suggests that certain forms of extended kin relations are perfectly consistent with the modern urban industrial society and homes for the aged. These forms are very different from those of the traditional extended kinship structure. If the

staff is to play a role in the setting up of proper kin relations to their institution, they should have a clear idea of the structure of such kinship units with which they are involved. In addition, they can design their own linkages to the kin that insure the proper balance. Thus the staff should know that the modern kinship system should ideally be a series of semi-autonomous units which has procedures for exchanging over geographical and occupational distance and which insulates such exchanges from those of the occupational world; and it has mechanisms for preventing such exchanges from leading to mergers and the traditional extended kin structure which would not be consistent with modern society and the homes for the aged.

Kinship systems play an increasingly powerful role as elderly people become more infirm because members of other traditional primary groups, such as the spouse, the friends, or other residents in homes for the aged, become increasingly infirm or die at the same time. The kinship system with its cross-generational structure size and commitment is often the only group with both the economic and physical resources to carry on. However, it would be a mistake to say that groups like friends, other residents, or spouses do not play a role, especially at early stages of institutionalization. This manual is not designed to deal with these groups, aside from some consideration of them as functional substitutes for kinship systems.

We turn our attention to a major issue highlighted by the theory of Shared Function and Balanced Coordination, the linkage mechanisms which can be used to alter the distance between the institutions and the kinship structures. These are the specific mechanisms the staff or kinship unit uses to either increase or decrease the distance between the two groups.

Chapter 11. Theory of Staff and Kinship Linkages

Kinship groups facing a staff are varied: Some are traditionally extended and nepotistically oriented; some are nuclear or nonkin oriented; some are mixed, with one unit being traditional and another stressing nuclear only; and some stress the modified extended family. Because of their range in types, the staff may, at one and the same time, seek to reduce the contacts of the traditionally oriented families while using aggressive outreach programs to draw in the nuclear oriented ones.

With these thoughts in mind, let us consider some family types and linkage procedures. The principles of linkages are based on the following elements:

1. The processes by which one gets a client's attention may be different and separated from those by which one actually produces changes in attitudes, knowledge, or behavior.
2. Sometimes, to change knowledge or attitudes or to get attention, it is necessary to use technical expertise and sometimes nontechnical behavior.
3. In general, either getting the attention of a very resistant population or managing change requires close face-to-face contact.
4. Crucial to the type of linkage one must use is the number of people in the target population.

The above considerations mean that those who design linkages must assess whether they are dealing with the problem of getting attention as well as managing change or only with the problem of change. They must determine whether the individuals in both processes are hostile or friendly. They must determine if the goals of the linkage require technical expertise or nontechnical resources; and finally they must determine if many people or few people are involved. We shall take these matters up one at a time and then put them all together, for, without question, the practitioner must ultimately consider them all simultaneously.

Problems of Selective Listening and Sender Initiative

In the past, social scientists studying mass media discovered that a major barrier to changing people was the problem of just getting them to listen. They found out that those people who were the major targets of change often were unaffected because they were the least likely to listen to the change message. They called this problem "selective listening" (Hyman and Sheatsley 1947). It was found in political campaigns that the people who generally listened to a candidate were those who already supported him. The rabid opponents would refuse to come to meetings, turn off television, and refuse to read the speeches in the newspapers. Campaigns to discourage people from smoking would often never reach those who were committed smokers; the people most likely to listen were those already confirmed in their view that smoking was bad. Similarly, it would be assumed that if the family was hostile to the idea of helping the elderly in homes of the aged, it would tend to turn aside letters or mass media appeals to come in and help. Those most likely to listen to such messages would be those who already favored helping.

Selective listening implicitly involves a distinction between those who are friendly and those who are not. To deal with problems of selective listening, one needs a linkage which permits face-to-face contacts between the sender and his audience.

To make this point clear, let us consider four hypothetical linkages that staff may use to reach kin. They may assign social workers to an outreach program where they are empowered to go right to the home of the kin and establish warm and friendly relationships with them, spending their time almost exclusively with one or two kin groups. This would be analogous to youth workers working with youth gangs in an outreach program, some religious missionaries living among the groups they hope to convert, or some agricultural extension workers seeking to introduce change into an agricultural community.

A second procedure for reaching the kin may be some form of mass media such as television programs, leaflets or brochures, which go to all kin. A third type of procedure may be institutional regulations which address themselves to kin visiting (e.g., open visiting hours or very

limited ones, parking spaces or not). A final procedure, which we do not think in fact exists, is one which would give to the staff the legal right to demand that the kin make contact under the law. It would be analogous to the legal rights to attendance officers in public schools.

These four linkage procedures vary enormously in their ability to put the staff of the home in face-to-face contact with the kin. For instance, the outreach or detached worker is being paid 8 hours a day to come into face-to-face contact with the kin. By contrast the mass media has no personal contact. It can reach the kin but only for the time it takes the kin to turn the dial on a television channel or to read the first sentence of a leaflet. However, if we consider the power of the staff to increase the visiting hours, we can say that this form of linkage has even less direct contact with the kin in that the kin may not even know of these regulations unless they first go to the trouble of coming to the institution. In other words, these three linkages can be graded in terms of the institution's ability to confront the kin in face-to-face contact with a message. The outreach worker who is face-to-face has the most powerful and continuous form of confrontation; the mass media can provide a momentary or headline contact but not a continuous face-to-face one, while those procedures by which staff changes its institutional rules require that the kin take considerable initiative to even find out about the rules. The first procedure is most likely to overcome the client's selective perception because the client has to work hard to avoid the outreach worker. By contrast, he only has to flick a channel or move his eyeball to avoid the mass media while in changes in nursing regulations he does not have to do anything at all to avoid the message. He has to take aggressive action to even hear the message.

The name "sender initiative" describes the fact that linkage permits degrees of face-to-face contact and therefore gives the sender more or less initiative over the audience as to whether the message will be heard or not (Litwak and Meyer 1974).

In general, when a staff is trying to reach primary groups, linkages with sender initiative involve nontechnical tasks. It generally does not take great technical expertise or economies of large scale to establish face-to-face contact with primary groups. However, there are times when this is not true, typically when the formal organization has legal power to demand contact. For instance, attendance officers in schools can make use of the power of law to compel parents to talk. If the family will not speak to the attendance officer, he is empowered to come back with a policeman, and, if that does not work, he is empowered to come back with the Army, Navy, and Air Force. It is the threat of this overwhelming technical expertise and the economies of large scale that forces people to listen.

In other words, staffs of homes for the aged have to use linkages which have sender initiative if they are attempting to deal with problems of selective listening. These linkages in addition generally involve nontechnical kinds of activities with economies of small scale. Logically, when the staff deals with kin who are already attentive, there is no need to use linkages with high initiative. Further, such passive linkages often involve technical expertise or economies of large scale, e.g., mass media, organizational rules on visiting, parking facilities.

Before exploring the implications of these remarks, it is necessary to note that so far only two elements of our scheme have been established—the need to have face-to-face contact when dealing with resistant populations and the need to consider whether or not the linkage will need technical expertise.

We have not as yet established the processes of getting attention as different from those of managing changes.

Problem of Selective Interpretation and the Management of Change

Investigators who studied communication found that, when they had a captive audience who had to listen to the message, yet another phenomenon occurred: People would selectively interpret what they heard or selectively forget what they heard so as to re-interpret the message to conform to their prior views. Thus, prejudiced people may reinterpret a joke aimed at them in order to support their position (Cooper and Yahoda, 1954; Hoveland, 1959). The possibilities of reinterpretation can occur both because language is fundamentally ambiguous and because the message may be very complex. For instance, Paul Lazarsfeld in class room lectures pointed out how the simple question, "Why did you buy this book?" could be interpreted in one

of several ways, such as why did you rather than someone else buy it, why did you buy rather than steal the book, or why did you buy a book rather than a toy. One can take yet another view that the person asking the question is not really interested in the question at all but simply trying to make conversation to pass the time, to use this question as a form of introduction to establish closer relationships. If one is trying to explain the complexities of the modified extended family and the need to differentiate between technical and nontechnical tasks, and why there is a partial conflict between primary groups and bureaucracies, there is far more room for reinterpretation than in the simple question: "Why did you buy this book?"

Even where it is possible to capture an audience and force them to listen, there is no guarantee that they will correctly understand the message. To overcome the possibility that people who are not congenial may reinterpret the message, it is necessary to have continuous face-to-face contact with them. Every time a message is given and the target group acts in such a way as to indicate they have reinterpreted it, the staff must be on the spot to correct the reinterpretation (Hovland 1954). We refer to the staff as focused management when they have the capacity to be on the spot in continuous contact with the client during the process of changes.

Again, the cause of misinterpretation or the basis for correcting it can be highly technical or nontechnical. When one is trying to change an attitude (e.g., kin are fearful of the home and all it stands for), the basic element is trust, which requires not technical training but either everyday interpersonal skills or sharing with the target group a common ethnic, class, and sex status. In contrast, when the change means trying to provide some technical information (e.g., teach kin the various medical tasks they can perform, such as giving shots for diabetes, turning sick patients in a bed, or the course the patient's illness will take, and demands on the kin at each stage), then the person providing the change may require some technical knowledge to be successful.

To insure that change takes place, one may need a person who inspires primary group-like trust and noninstrumentality to be in face-to-face contact. Or one may need an individual who inspires trust in a bureaucratic sense—he is a trained expert. There are two kinds of focused management—one involving continuous contact under the conditions of noninstrumental orientation, the other requiring face-to-face contact under conditions of trust in expertise. We will call the first, primary group intensity, and the second, bureaucratic intensity (Litwak and Meyer 1974). Having made this distinction between expert and nonexpert, we should also be clear that there are times when both expert and nonexpert tasks are simultaneously involved. In such cases the individual must handle both primary group trust and expertise trust and be in a face-to-face relationship.

If we consider the four linkages we described above, clearly one of them, the outreach worker, is trained to handle both problems of primary group trust and bureaucratic trust on a face-to-face basis. As a linkage, it has both high sender initiative and high focused management in the primary group and bureaucratic intensity. By contrast, neither the mass media nor the changes in visiting rules reflect close face-to-face contact. Of the two, the mass media could include substantial amounts of technical information but not permit face-to-face exchanges. Both are low in sender initiative and focused management. The legal mandate for linkages could, like the outreach worker, bring to bear technical knowledge. In general, people with legal mandates to use force find it difficult, as an empirical matter, to also engender great degrees of primary group trust, though they sometimes do. Therefore, this linkage may be high in sender initiative and focused management, but only in the technical areas.

The main point to keep in mind is that the processes by which one gets the audience's attention may differ from those by which change is managed. Both must be considered by the staff.

The Problem of Scope

This brings us to our last variable, the problem of scope—how many people is it necessary for the staff to reach with a particular linkage? For instance, if the staff are conducting a fund-raising drive or voting drive to get legislation favorable to the home, they will often need linkages which require very high scope, such as mass media. On the other hand, if the staff have a program designed to train a small number of kin, who have nuclear family orientation, in the virtues of having a modified extended family approach and intend to use a weekend retreat for

this purpose, they would want a linkage with very narrow scope. If they use mass media they may attract many kin who are already favorably disposed and who are seeking additional guidelines. Such kin may flood the weekend retreat and leave no room for the people who really need it. In such cases the staff may want to use discrete telephone calls as the linkage which permits only a few people to be invited.

Theoretically, scope, like the other dimensions, may have both technical and nontechnical aspects to it. However, in general, the greater the number of people, the more the linkage must use economies of large scale and technical expertise. We think it is true regardless of the kin's distance from the staff.

With these dimensions in mind, we can restate the theory of Shared Function and Balance Coordination. When the community is resistant, it is generally necessary to have linkages which put the staff and community in close face-to-face contact. Such close contact, though necessary for exchange, increases the danger that the atmosphere between the bureaucracy and primary groups will lead to conflict. If the task the two are exchanging involves nontechnical matters which require that the staff use a linkage with primary group intensity, then the danger may arise that primary group norms will be introduced into the bureaucracy. On the other hand, if the linkage is one which requires a change of technical matters, the dangers are likely to be the introduction of impersonal contractual relationships into the family. In general, the increase in danger by close contact is compensated for by the increase in coordination between the technical and nontechnical aspects of the same tasks. However, when the community and the staff are fairly friendly, using any linkage which produces continuous, close face-to-face contact is likely to lead to overinvolvement because of the conflict in structures.

One of the implications is that the staff of a home may have to shift their position with regard to any given kinship group. If the kinship group starts out as very resistant, the staff may want to use an outreach program. However, if the staff are successful and the kinship group changes its views, the staff may want to shift to a more passive linkage which opens up the social distance.

With these thoughts in mind, we should like to put down a chart where we examine some obvious types of linkage and show how they may be rated in terms of the dimensions of distance opening and distance closing. This table could be used as a model by which staff may assess any given linkage that confronts them. If they assess its sender initiative capacities, its bureaucratic and primary group intensity, and its scope, then the staff should be in good position to say what any linkage will do as far as opening and closing social distance are concerned. The actual linkages listed are not what is crucial about this table but rather the basic theoretical dimensions — initiative, intensity, and scope. No matter what the linkage is called, whether it is new or old, if these basic dimensions can be assessed, it is possible to estimate whether it is appropriate for opening or closing distance. Even more important, sometimes one can assess the nature of kinship groups one is trying to reach and from this derive the theoretical properties of the necessary linkage; that is, from the degree of sender initiative, bureaucratic or primary group intensity, and large or small scope, one can invent or construct a linkage to fit the situation.

With these thoughts in mind, let us look at some forms of linkage that staff could use and assess their underlying properties as indicated in Chart I.

In Chart I certain assumptions were made about the empirical linkages in order to suggest an overall rating. However, some of these linkages should be structured in different ways, and, depending on how they were structured, we would rate them differently. For instance, voluntary associations could be very massive affairs which meet twice a year in which an invited speaker discusses some topic of concern and there is not interaction of kin with each other. On the other hand, voluntary associations can consist of a small number of key kin who meet several times a week to exchange services regarding the nontechnical aspects of aid to their kin. These latter groups might either involve sharing certain tasks with regard to their relative such as making sure he eats the food that is placed in front of him, turning him in the bed if he has to be turned, or taking him to the toilet if he cannot walk by himself. Alternatively, the kin group might be organized as an advocate group whose main job is to continually watch the staff to insure that they don't abuse the residents. These three forms of structure can all be called voluntary association.

Chart I

Underlying Properties to Typical Linkages From Formal Organizations to Community Primary Groups

Empirical forms of linkages	Problems of getting attention (selective perception)		Problems of producing change (selective interpretation)		Reaching many people
	Sender initiative		Focused management		
	Primary group intensity	Bur. intensity	Primary group intensity	Bur. intensity	Scope
1. Outreach worker	High	High	High	High	Low
2. Volunteer association	Low	Low	Mod.-Low	Mod.-Low	Mod.
3. Institutes for training kin	Low	Low	Mod.	High-Mod.	Mod.
4. Kin on policy boards	Mod.-High	Mod.-Low	Mod.-High	Mod.-Low	Mod.
5. Indigenous nonexpert staff	High	Mod.-Low	High	Low	Mod.
6. Individual conferences	Mod.-Low	Mod.-Low	Mod.	Mod.-High	Low
7. Telephones	Mod.-Low	Mod.-High	Mod.-Low	Mod.-Low	Mod.-Low
8. Mass media	Mod.-Low	Mod.	Low	Low	Highest
9. Use of community opinion leaders	Low	Low	High	Low	Mod.
10. Getting visiting hours	Lowest	Lowest	Low	Low	High
11. Providing parking facilities	Low	Low	Low	Low	High
12. Rules on kinship exchanges	Low	Low	Low	Low	High
13. Formal authority	Low	High	Low	High	Mod.

The term, voluntary association, is not the central feature for purposes of staff diagnosis. What is central is the extent to which each of these linkages requires staff initiative, the extent to which it can bring to bear primary group intensity, the extent to which it can bring to bear bureaucratic intensity and the extent to which it involves many people or few. In the above case, the three linkages would differ considerably on several of these dimensions, and we would think of them as different even if they were all called voluntary association.

In chart I we are suggesting that staff could have a linkage such as an outreach worker which would permit staff initiative of a primary group and bureaucratic kind as well as staff-focused management change involving primary group intensity and bureaucratic intensity. Such a linkage would have very limited scope the more it had the other qualities because, to have focused management and staff initiative, the staff would almost have to have one staff person to one group. There are obviously variations of this linkage such as nonexpert staff who are hired to

go out and recruit and change indigenous kin groups. The assumption here is that only nontechnical aspects of selective listening and focused management are necessary and that indigenous people are more likely to be trusted by the kin. Similarly, the assumption is made in this particular designation that the change problems involve nontechnical tasks. Indigenous, in this case, means the matching of the basic statuses of the kin system with the staff, e.g., ethnic group, education, religion, occupation, and class. Thus, if the kin group is a working-class first generation Puerto Rican Family, the worker who is sent out might also be of the same status. The use of indigenous people generally rules out the development of high levels of expertise because it is often difficult to match technical training with the various unique combinations of social status. Where high levels of technical training are required in the outreach program and the populations are very diverse, efforts are often made to give the expert some training in the local culture rather than to find people from the local culture who are experts.

In contrast to the outreach worker, linkages such as mass media have little sender initiative and little direct staff focused management of the change process. The same can be said about the staff rules governing timing of the kin visits, possible kinship exchanges, parking, etc. These are linkages which are passive and therefore are helpful only with kin who already have considerable interest in coming. They are not very helpful in reaching kin who have strong feelings against coming. These are linkages which, by themselves, have very little effect on changing kinship behavior but rather accelerate or decelerate behavior orientations which the kin already have. With these thoughts in mind, we might consider some types of kinship and the kinds of problems which confront the staff of a home for the aged and the kind of linkages the staff should use to handle these problems under the balance theory of linkages. Again the effort is to show the reader how to utilize the principles of linkages and shared function rather than to say something about the particular cases involved.

Problem of Underinvolvement Where Kin Want to Help

There is some evidence that a very substantial number of residents of homes for the aged have some contact with kin (Dobrof 1974). There is also evidence that many kin feel very guilty about their parent being in such homes and feel in some sense that they have failed in their duty. One possibility which should be entertained is that many of these people do not understand that there is a great deal they could do for the residents of the home because the principles of shared functions still operate in homes for the aged. Such kin should be informed about the way this works with respect to nontechnical tasks over the entire range of activities from the medical nursing aid, to the special food treats, the special problems of tension management, and the insurance of proper treatment of the staff.

The material from works, such as Gottesman (1972), which shows that people with kin receive better treatment, should be conveyed to the kin so that they will see these services are still important. What kind of linkage would be necessary to reach such kin? Since many of these kin may be making visits to the home already, an aggressive outreach program may not be necessary. All that may be necessary is for the staff person to contact them during one of their visits. For the purpose of changing their orientation, they may need a series of meetings with a staff expert or with other kin who have successfully implemented such an approach. The meetings would be halfway between a classroom lecture and a self-help program or apprenticeship experience with staff and other kin sharing the leadership. A recitation of experiences and how they were handled, the use of simulated interactions like role playing to make the point, and even some supervision with one's relative in the home by more experienced kin could characterize this activity. In short, a linkage which is passive, that has moderate degrees of primary groups focused management, moderate to low degrees of expertise, and moderate degrees of scope is called for. The assumption is that this group of kin will attend, but they lack knowledge of the nontechnical tasks and therefore selectively misinterpret their role.

Problem of Underinvolvement of Kin Based on Strong Belief That the Nuclear Family Is Ideal and All Exchanges Between Kin Are Morally Wrong

In contrast to the first group of kin, there may be another kind of kin who feels that all forms of kinship aid are morally wrong. They strongly believe that one's whole responsibility is to one's spouse and to one's children when they are young, but later everyone must take care of himself. They often do not think as a sociologist that one kin aiding another leads to nepotism and a class-crystalized society but rather see the issue more personally, that people must learn to make their way on their own. Those who cannot make their way on their own fail because they lack either the ability or moral fortitude. To help them would be unfair to others in the society and would not increase their moral character.

Such kin clearly do not see the role of the modified extended family, nor do they see the differences between kinship exchanges which deal in the nontechnical areas of life and those which deal in the technical areas of life. Only the latter lead to corruptions. This kind of kin constitutes a very small minority of the population, though some elements of their thinking may be in all people. But rarely is their thinking such that they do not maintain contact with relatives in homes for the aged (Dobrof 1974).

Bringing these kin into contact with their relatives requires an aggressive outreach program. How aggressive depends on how strongly the kin feel. Those who feel less strongly may be brought in by a telephone call. Those who feel even more strongly may require a visit and actually have the staff person bring them to the home. Those who are even more strongly convinced may require much stronger commitments of staff time, that is, demand that the staff spend several hours, several times a week, before change can take place. To change such kin's attitudes regarding the role of exchange between nuclear units may require either a staff person

specially skilled in attitude change or an indigenous person who is strongly admired by the kin to show them in an apprenticeship way that their prior sense of such exchanges being morally wrong is incorrect. Because the scope is very low, one can begin to think of procedures where either indigenous staff or outreach workers are used to produce change in a one-to-one relationship with the kin.

Problem of Overinvolvement Based on Lack of Knowledge of the Relationship Between Technical and Nontechnical Tasks for New Families

Still another kin type which might confront the staff is those who feel a very strong identification with their elderly relative in the home. It is not so much that they have a concept of the traditional extended family but only that in this context they lost sight of the need to keep the administration of technical tasks and nontechnical ones separate. As a consequence, they are constantly pushing the staff to make extra services available to their relatives—they want doctors to handle the nontechnical aspects of medical services for their elderly relative or they tend to be hypochondriacal on behalf of their relative (that is, insist on much more medical attention than is needed). Their intrusion may lead to their relative getting unnecessary medical attention while other more needy residents get less. Alternatively, they may pay the staff extra money on the side to insure that their relative gets first crack at limited recreational resources (that is, gets fed at the time he wants to get fed, gets his choice of roommates, etc.). These extra services to their relative are often purchased at the expense of other, more needy residents in the home.

The kin in their single-minded, noninstrumental attachment to their relative may not see that this pressure on the staff is resulting in poorer technical treatment to other residents. The staff have to encourage the kin to reduce the level of their involvement or alternatively to move it into different channels (e.g., spend more of their own time doing the things they are now asking the staff to handle). In a single case, the staff can utilize a linkage with narrow scope. Ideally they would like to set up rules which would limit their contact with kin visiting in the home. Since this is difficult, what they may alternatively consider is a series of conferences—passive in character. Since the relative is very likely to be in the home, the staff can approach him or her during a visit. The attempt should be made to point out how the relative's behavior is making it difficult for other residents in the home. The staff must find an alternative activity for the relative which will on the one hand give him a sense of helping but on the other hand reduce the primary group aspects of his contact. Thus the staff may suggest that the relative can help both his kin in the home as well as other kin if he aids in a lobbying effort for new funds from the legislature or aids in a fundraising drive for the home, which would enable the home to hire more doctors to give more medical services to the elderly relative and other residents. Such a fundraising effort would move the kin out of the home and reduce the contact with the operating staff while at the same time giving the relative a sense of helping. If fundraising is not possible, the relative could join another program, like a voluntary service club, in which kin and friends provide supplemental nontechnical services such as driving elderly to outside recreational facilities. This activity, like the prior one, would reduce the direct involvement of the kin with the relative and staff but may nevertheless give the kin a feeling that he is helping.

The type of kin we are speaking about would of course be more difficult to deal with if he were located in key power positions in the home, for instance, if he is on the board of governors of a home for the aged which depends on private philanthropy. Where the kin in question are big money givers, their power to distort technical tasks is enormous. In this case, the staff face the enormously difficult and delicate task of persuading the kin that they should not use their obvious power to interfere with the technical tasks and large-scale economies. The staff must persuade this powerful individual that his talents are best used for his relative and the other residents by aiding in fundraising and participating in linkages like formal organizations which reduce his personal contact with the staff of the home.

Problem of Overinvolvement Based on Traditional Families' Orientation—No Distinction Between Technical and Nontechnical Tasks for Large Numbers of Families

It is possible that the home for the aged may have a special clientele where the families main-

tain a more or less traditional kinship orientation. This orientation assumes all relationships are nepotistic and does not recognize the fact that staff of bureaucracy can operate on principles of merit. This is a very unlikely event in modern day America. Yet, among certain subpopulations in American society there may still be those who adhere to this formulation (Gans 1962, Goode 1963). In general, such families will not permit their elderly to come into homes for the aged but will insist on taking care of the elderly within the context of the kinship structure. However, if by some rare chance a given home happens to have substantial numbers of such people, it will find itself being invaded by kin who constantly seek to persuade the staff to give special privileges to their kin. They will consistently violate any residential rules whenever it suits their nepotistic views. Such kin can do wonders for the resident as far as the nontechnical aspects of care are concerned, e.g., they may bring their relatives three meals a day so that they do not have institutionalized food at all. However, they may also introduce such nepotism into the staff that the only people getting adequate medical services are those with the richest and most powerful kin. The others may get completely inadequate service.

In situations like this, the staff should move to protect themselves in insisting on a program which limits kinship involvement. They may introduce rules which strictly limit the hours in which kin can visit. The rules may be far more restrictive than the staff feel necessary, but, since the aggressive kin can be expected to violate the rules, the combination of strict rules and aggressive kin may lead to the level of activity which is desired.

In addition, the staff may seek a program of resocialization of kin to take place outside of the home itself if at all possible; if not possible, then to at least prevent the staff who treat the elderly client from contact with the kin so that the nepotistic influence on the staff cannot directly affect the treatment of the client. This program may involve nonstaff people, such as community leaders or outside professionals, who try through a series of experiences, as well as primary group trust, to get the kin to redefine their relationships to staff and elderly resident. The meetings may therefore take place in a local church or ethnic organization. If they are held in the home for the aged, they should be held in the evening in a recreational room that is isolated from the residents. They should not involve staff in charge of supervising the residents. The key idea is to both carry on a resocializing program and at the same time reduce contact with the staff in charge of supervising the everyday activity of the elderly resident. We have little hope for resocializing efforts since such processes are not well understood or easily carried out under the best of conditions. Most homes do not have resources to do this kind of training. On the other hand, it is difficult to conceive of a substantial group of people with strong traditional kin orientations both existing in America and at the same time having their relatives in a home for the aged.

Usually there are some relatives with moderate overinvolvement with their kin who basically understand the need to distinguish between the administration of technical and nontechnical tasks. For these people the modest types of resocialization may be sufficient.

Problem of Involving a Large Number of Kin Who Are Already Committed

The staff may on many occasions want to draw on kin who are already committed to the home and its program, and they may need large numbers of such kin. This is typical in fundraising efforts or in political efforts to get the legislature to provide more money for the homes for elderly. In such cases, the staff may only need a linkage mechanism that is relatively passive (that has only moderate sender initiative), but does have very large scope. Depending on the technical character of the task, they may require more or less primary group or bureaucratic intensity in focused management of the event. Thus, if the action involves circulating and signing petitions, the staff may reach the membership by using mass media (mailings, leaflets, or radio announcements). The effort involves getting people already committed to the home to take a petition, circulate it, and fill it out, or to indicate that they would be willing to sign such a petition to be sent to them. If the problem is direct fundraising, the call may be for both direct contributions and volunteers to help staff a fundraising program. This mass of linkage is often very inexpensive if one computes the per unit cost of reaching individuals. It is needlessly expensive to send an outreach worker to persuade people who were already prepared to help. It also runs the unnecessary risk of overinvolvement.

Problem of Involving Kin to Handle Staff Violations

This book is directed to instructing staff how to relate to kin groups so as to maximize the resources available to elderly residents of homes for the aged. However, it should be understood that sometimes the problems arise from staff misconduct. We pointed out earlier that, given the conflict which inevitably arises between the administration of technical tasks and the handling of nontechnical ones, there will always be some incentive, even in the best of staff, to move in directions which minimize the handling of the idiosyncratic needs of the elderly residents. This is especially true in nursing homes where the bulk of the residents are severely ill and in no position to assert their needs.

The problem is magnified tenfold where the staff is not the best. It must be considered that the care of the aged does not have a high priority for many people. As a consequence, the amount of money to pay staff is not great, and therefore the staff are neither motivated nor are they often able to deal with the idiosyncratic needs of residents. The preservation of staff time and energy is an overwhelming need, considering their low pay and tendency to be understaffed. As a consequence, they can be positively abusive in their efforts to routinize resident activities so as to minimize their own work.

In such cases a wise administrator or the kin of the relatives may find it necessary to have the staff more closely supervised by a group who have the clients' interest very much at heart and who are physically vigorous. The relatives and friends of the kin are probably the group who are most likely to have internalized a need to help their elderly relative. Furthermore, they are perfectly capable of evaluating the nontechnical aspects of staff activity, e.g., medicine, feeding, recreation, homefurnishing. This is in part reflected in Gottesman (1972) who points out that the aged who have relatives tend to be in better states of health. The wise staff have a rule of thumb which says, even if a resident is completely senile, relatives should visit at least once a month to keep the staff honest. The relatives can spot marks of physical abuse and are sufficiently motivated to pursue with some vigor the source of such bruises. Furthermore, they have vested interest in siding with their relatives if there is a dispute. Knowing this, many staff are careful not to abuse residents who have visiting kin. Our theory suggests that the more abusive and incompetent the staff, the greater the need for relatives to organize on a systematic basis so as to insure some kin in the home at all hours, thereby decreasing the distance between staff and kin. It means a linkage with high kin initiative, moderately wide scope, and primary group intensity, i.e., an advocate voluntary kin association.

It is also clear from our analysis that this procedure may suffice for the nontechnical aspects of staff abuse but does not help the handling of the abuse in technical areas. There is no way that the relatives can judge whether the staff's doctors are prescribing the right medicine, the structure of the building is sound, the food purchased has been properly inspected, etc. For the handling of such technical matters, the kin must have experts who represent them in evaluating the technical aspects of medicine, the structure of the building, the freedom of food from diseases, and the nursing care.

To do this, the kin need a linkage with high initiative, high technical expertise, and moderately wide scope or a linkage which can be called an advocate expert.

It is not our intention to pursue all possible situations since the number might indeed be too many to encompass in any given manual and might be constantly growing or changing. The point of these illustrations is to show how the staff and the community must at any given moment make a diagnosis of the technical nature of the task, the extent to which the target group is attentive or not, the extent to which change requires focused management, and the extent to which it requires scope. Once these factors are designated, the staff should be in a position to determine the kind of linkage they need, as well as to evaluate the potential effectiveness of suggested linkages.

Organizational Structures and Linkage Mechanisms

The very structure of the organization affects the extent to which one can use a given linkage to reach the kin. Also, the structure of the organization is a factor in its own right which encourages or discourages contact of relatives. Thus, any linkage, like the outreach worker, which requires staff discretion and developing of trust relationships, cannot operate in an

organizational structure which puts great stress on rules and hierarchy for handling decisions. Organizations which are designed to maximize economies of large scale are generally not good for linkages such as an outreach worker.

It should be understood that when we developed our scheme we were speaking of extreme types of organization, that is, formal organization and primary groups. In fact, organizations can vary on a continuum (Litwak and Meyer 1974; Perrow 1967; Thompson 1967) going from the one extreme (rationalistic) to one which is somewhere between rationalistic and the primary group and is often called a human relations structure (Whyte 1961). The more the linkage requires decentralization of decisionmaking and trust relationships, the more the formal organizational structure must be toward the human relations pole of the continuum.

The more the organization moves toward linkages which require centralized coordination and little staff discretion, the more the organizational structure must move toward the rationalistic pole. A home cannot run a massive outreach program if its internal structure is extremely rationalistic, and it cannot run an effective mass media program if its staff are extremely human-relations oriented. It is, of course, possible in these cases to split off the task of linking from the task of administration. Thus, the human relations staff may assign a mass media program to an outside group. However, insofar as the staff must be directly involved in both linkage and administration, the contradictions will likely hold. Both staff and kin should be very dubious when an organization says it believes in a grassroots relationship with the community but is structured in a rationalistic way. It is quite likely that the grassroots program will be on paper only.

The more the organizational structure of the home moves toward a human relations structure, the less antithetical its structure is to the primary groups. As a consequence, the home can operate at a much closer distance than homes which are set up on a rationalistic basis. To some extent, administrators and the community have some choice on how the home should be set up. All things being equal, such homes should be set up toward the human relations end of the continuum because they have to incorporate people on a 24-hour basis and they must deal with nontechnical tasks which are best handled by human relations structure.

However, there are boundaries to such a mandate. For instance, as illness becomes an increasingly important aspect in the population of the aged, the home has to move to a more rationalistic structure in order to deal with the more technical aspects of illness and, consequently, needs economies of large scale.

Basically, there are alternative administrative styles. In homes for the aged the nontechnical tasks of everyday living are much more important than in formal organizations, like automobile plants where a car is the chief product. Therefore, in general, homes for the aged should be set up on a more human relations structure because part of their task is the maintenance of nontechnical aspects of life. Yet, as elderly people become ill, the technical tasks of medical care come to the forefront, and the custodial tasks of providing food and shelter require economies of large scale. These in turn require a more rationalistic structure to administer.

Alternatives to Kin Groups

We have stressed kin groups and we have not stressed other primary groups, such as friends, spouses, groups of residents, volunteers (Litwak and Szelenyi 1969, Rosow 1967), because, in general, there is a variety of primary groups in the society which can indeed provide aid to individuals in the nuclear family units. However, for the elderly and especially for those who are ill, the kinship group takes on particular importance (Rosow 1967). In other stages of the life cycle, it may not play this dominant role.

The kinship unit takes on this importance because the central fact of age (which is associated with physical fragility and limited economic resources) means that primary groups based on peer relations (spouses, friends, and other residents in the home) often do not have the resources necessary to aid their aged peer. For these same reasons, peer relations at this age level must be viewed as relationships of short tenure – peer groups have very high death and illness rates. We do not rule out the possibility that groups such as residents could be organized in new ways to compensate for their physical fragility, limited economic resources, and short tenure. However, at this time most groups, as such, still assume considerable physical vigor. In

contrast, kinship systems are characterized by cross-generational relations—the people involved are more physically vigorous and in better economic condition.

The question may arise as to why the staff of the home cannot take over the duties of the kin. There are two reasons: One, suggested above, is that staff seeking to do both nontechnical and technical tasks may be in conflict because the carrying out of these two tasks requires contradictory administrative procedures. In more commonsense terms, there may be temptation for staff who become highly involved with a given client to provide him with special services at the expense of others, or, alternatively, for a staff who develops great dislike for a given client to unfairly withhold technical services.

At this point, the persistent critic may suggest the use of two different kinds of staff, one to handle the technical matters and one to handle the nontechnical. Perhaps a program, like a foster kin, might be arranged which could be staffed by people who are indigenous to the client in terms of ethnic, religious, educational, and occupational interests and would not necessarily have to have technical training. The foster kin could be paid like the foster parent (but the role the paid person is asked to undertake may be quite different).

We think such an approach might indeed be necessary, but we would recommend it only in situations where regular kin are not available. Caution is introduced because the handling of nontechnical matters is not easily evaluated by a formal organization. As noted earlier, such nontechnical tasks involve unpredictability, and interaction is so quick that it is hard for any outside agency to supervise. For the kin members, outside supervision is not necessary because they have internalized the noninstrumental orientations. The kin do what they can for their relative because their relationship to their relative is good in itself.

With this point in mind, it becomes clear why the use of a paid foster relative is a secondary choice. There is no way to insure that a stranger will have a noninstrumental orientation to the elderly, a point of difference between traditional foster care programs and the proposed foster relative program. That is, society might be able to count on adults in America to develop positive affect toward children, whereas such affect would not be as readily available toward elderly people. Our culture tends to operate in this direction.

The use of volunteers may be yet another solution, again, necessary in the absence of relatives. However, it should be understood that the demands of the elderly are great, that many of the tasks the kin have to do are unpleasant; it is never a pleasant thing in American society to watch a loved one die. If we are asking volunteers to have emotional involvement as part of their ability to handle the nontechnical tasks and, at the same time, to put themselves in a position where they must engage in watching those they are involved with die, we may not be able to get many people to volunteer. Alternatively, once the volunteers realize the depth of the problem, they may quickly drop out of the program.

With these qualifications, it is clear that there are times when people either do not have any kin (very rare) or have so alienated them that they are no longer able to function in a kinship relationship (not so rare). In such situations, the use of staff, foster relatives, volunteers, and organizations of residents may be an alternative which must be considered despite its limitations. Insofar as these remain relatively small programs, it is possible that people who are heroes (that is, have capacities above and beyond the average) can be used to make them function effectively. In small programs it may be possible to find volunteers who can become emotionally involved and yet handle the negative experience of death, foster families who deal with nonuniform events in an honorable way even when not supervised, staff who can maintain their objectivity in technical matters even when emotionally involved, and residential groups who can manage to give aid and succor despite their own frailties and lack of resources.

There are many aged living in homes for the aged who are sufficiently robust to make good use of resident groups, volunteers, and outside friends. Even among the very fragile who have kin, volunteers and outside friends can play important supplementary roles. Thus, volunteers can drive the aged to various entertainment events, aid in shopping, etc. Often overlooked is the ability of such groups to aid indirectly by providing babysitting for children of kin so that kin can visit. Though this manual stresses the role of the kin and their increasing centrality as the aged become infirm, the staff will be well advised to keep in mind other types of primary

groups. The staff relations with such groups have general characteristics that are the same but, because the structure of these primary groups differs somewhat from the kin (Litwak and Szelenyi 1969), there may be differences as well (see Appendix I for Part II).

It should also be pointed out that kinship systems are often very large. In general, the children of the aged will be those most involved with elderly in homes. However, it is important to recognize that, where relationships with children are not possible (there are none or they have been destroyed over time), grandchildren, cousins, nieces and nephews, and siblings should be considered. One of the strengths of the kinship system is its size. To use kinship systems profitably, the staff should eventually become expert in varying roles and commitments of different kinds of kin. For initial information on such matters, see Part I of this manual.

Chapter 13. Summary and Conclusion

In the preceding chapter we pointed out that completely different administrative styles or group structures are necessary for maximizing technical and nontechnical knowledge. Both kinds of knowledge are crucial for solving most tasks. The need to coordinate technical and nontechnical knowledge requires the staff to operate on a balance principle of coordination. That is, they must bring staff and community close enough to coordinate the technical and nontechnical parts of the task, but they must also keep them sufficiently distant so that their conflicting structures will not lead to mutual destruction. Some people do not recognize the need for the nontechnical tasks and, as a consequence, push for the isolation of staff from kin. Others do not recognize the need for technical staff to be isolated from kin at all and push for the complete merger. We adopt the view that there is a shared function between kin and staff which covers a large range of activities and that the structure of kinship groups and staff relations are antithetical so that it is necessary to keep some distance even while coordination takes place.

Specific principles of linkages follow this analysis—the staff may be in a position to either increase or decrease distance with the kin as their relationships become too close or too distant.

In this context, the modern kinship system may have structures very different from past kinship systems; the staff should be aware of the principles of modern kinship systems. They must be aware that these systems represent a confederation of nuclear units, that is, they are semiautonomous. Within the confederation there may be exchanges among the units in some areas of life and not in others. Furthermore, staff recognize that exchanges must be restricted to the nontechnical and isolated from the formal organizations. Maintaining exchanges in an industrial system requires the art of communicating over geographical distance and across class lines. The staff must be familiar with these arts and encourage their growth. In addition, such systems require procedures to insure that the kinship units do not merge and become a traditional kinship structure rather than the semiautonomous units they are. It is the inability to conceptualize the semiautonomous state that often causes kinship members to pick one extreme of stressing complete autonomy or the other extreme of complete merger. Highlighting ways of exchanging which permit autonomy is very important for the staff so that they can reduce the dilemma of the kin. The concepts of reciprocity, especially as they pertain to time and kind, are important. The highlighting of the use of institutional gift giving and the maintenance of multilateral kinship ties are also important.

In conjunction with the need to understand the modern kinship system, alternative primary groups are not recommended for elderly ill people in homes for the aged or nursing homes, either because of the frailties of peers or the inability to guarantee supervision. However, where kinship ties are not avialable, various forms of substitutes should be developed.

At this point the reader may be overwhelmed with the various factors that must be taken into account. The experienced practitioner on further thought may point out that there are many contingencies as yet not covered by our speculations. In part, the lack of coverage means lack of knowledge. There may be many experienced social scientists who would say that the propositions we have suggested are scientifically reckless, given the nature of data available.

The dilemma between saying too much and too little reflects the state of our science and the state of the field. The intelligent reader will take these states into consideration when reading this manual. It is intended to help, not hurt, the staff member and the residents. The staff member must look to the general principles we have enunciated and use them as guidelines to organize his own unique situation. As guidelines, they fit anywhere from 10 percent to 90 percent of the particular situation which confronts the staff. The staff must exercise their own ingenuity to see how to translate the idiosyncratic elements of their situation into the principles suggested here. In addition, the staff must understand that our principles are the best estimates we have at this time, and staff have a

responsibility to judge these principles against their concrete situations. Where the situation clearly goes counter to the principles, they should drop the principles. In other words, the principles we suggest should be used if they indeed aid in organizing a job more effectively. It will be the continuous exchange between the theories and practice that will eventually lead to the development of principles of greater use to all concerned.

Appendix I for Part II
Other Forms of Primary Groups: Residents, Friends, and Nuclear Family Units

In this manual we are concerned with kinship systems, generally the key group in nursing homes where individuals are too sick to develop resident primary groups or to deal with friends and often do not have spouses. However, in homes where the key group differs, we should say a word or two about resident groups. In many ways they resemble neighborhood groups in the outer society; they are defined in terms of geographic propinquity. There are several kinds of neighborhoods. The traditional neighborhood is defined in terms of people who see a given land as a permanent place of residence and expect to spend a relatively long time in that spot, expecting neighbors to be there for a long time as well. All strangers are seen as aliens, and it is a serious insult if a member of the group wants to leave.

Like the traditional family, the traditional neighbor sees all relationships as governed by nepotistic rules. Gans describes one such neighborhood (1962) as do Warner and Lunt (1941) and Whyte (1955).

In contrast are those neighborhoods in modern society which are organized and, at the same time, are legitimately mobile (Fellin and Litwak 1963; Festinger et al. 1963). Moving in and out of the group is expected and is not viewed as a hostile act. The question arises in such cases as to how a neighborhood can maintain any sense of cohesion if people do not envision permanent residence for a long period of time but envision being in the neighborhood only for a short period of time. Such groups can manage intensive exchanges if they have rapid modes of integrating newcomers. Thus, when a newcomer moves into a neighborhood, there is a set of cultural norms that sanction mobility in and out of the group or norms which view mobility as akin to betrayal. People in the groups may be assigned to meet newcomers—the welcome wagons or clergy who welcome new people. Local voluntary associations may be publicized for which membership is easy and which, in turn, offers strangers an opportunity to meet local people or hear local issues discussed. Newcomers may be introduced under auspices which are likely to stress the similarities between newcomers and current members of the group. There can be architectural planning which insures that people will have maximum contact with each other (Festinger, Schacter, and Back 1963). Finally, people can be taught to view interpersonal skills as having social origins rather than biological ones so that they will be willing to discuss primary group interpersonal problems with relative strangers because they feel that they can learn and benefit. Because of the need to hide biological defects, they no longer refuse to discuss such matters with other than trusted long-time friends.

Residents in homes for the aged and, to some extent, nursing homes have some of the characteristics of these mobile neighborhoods. However, the mobility and short tenure are not caused by occupational advancement or changes in the family life cycle but by the fragility of the older people, with death and serious illness causing people to be removed.

Older people who are residents of a home for the aged have the same virtues of any neighborhood group. They can, because of their immediate geographical propinquity, deal with time emergencies—call staff members if a resident is suddenly struck down by a heart attack. They can also provide supplementary nurses aid services; they can provide each other with the nonuniform aspects of leisure; they can provide some aspects of physical protection by calling for help or aiding the police to identify criminals. However, the more nursing homes have a population dominated by older people who are seriously ill or senile, the less likely they are to have meaningful exchanges among residents.

There is yet one other type of neighborhood and that is a mass neighborhood where no meaningful exchanges are made among neighbors. If the home for the aged consists of such resident groups, the elderly will not have benefits from primary group support where geographical proximity is important or where time emergencies are crucial.

Finally, there are volatile neighborhoods which consist of several subgroups in conflict with each other. These present special problems for the staff in that they must continually deal with problems of conflict which in turn prevent the staff from carrying on their technical tasks (Litwak and Meyer 1974).

We would ordinarily think that the resident primary groups organized for change would be ideal for the elderly in homes for the aged. Since the staff must provide resources so that mechanism of quick socialization takes place, the staff may provide rooms and resources for local residence clubs. The staff must introduce the new resident to key members of the resident groups. The staff arrange staff activities so that residents will have the maximum opportunity to meet other residents. The staff may provide training for residents in the use of mechanisms of quick integration (Fellin and Litwak 1963).

Another kind of primary group, ordinarily the key one, is the nuclear family. Many people who live in homes for the aged or nursing homes do not have spouses; they are incomplete nuclear families. Nuclear families are the most effective form of primary group structure where the group does not require resources having more than two people. Nuclear primary group members are not able to deal with nonuniform aspects of tension management when the cause of tension management is fights between husband and wife. A primary group member outside of the nuclear family member generally is needed to handle such problems of tension. It often cannot handle problems of illness which, though handled at home, require a 24-hour watch over the patient for a week. In such cases the spouse may have to be supplemented by kin. Older people who have just retired may not have a good idea of the nonuniform aspects of retirement because it is not within either spouse's immediate experience; in such cases they may have to go to primary groups (such as friends) who have undergone the experience and who are outside the husband and wife relationship. These are only a few of the more obvious instances where the nuclear unit does not have enough effective resources.

However, when the nuclear unit does have sufficient resources, generally it is a faster and more flexible unit of decisionmaking because there are fewer people to take into account when making a decision. Therefore, there is an enormous incentive to leave these nuclear subunits in a semiautonomous state so that when they have tasks which can be handled by the two-person group, they can act autonomously, while if they have activities which require more resources than the two-person group they can exchange with relatives, friends, or neighbors.

In fact, the staff must confront the fact that nuclear family units may not understand their function; they may decide to act as individuals and not help each other or to merge with the kinship unit. The attempt to act as an individual means the loss of nuclear family aid; the attempt to merge leads to problems of nepotism in the staff; or, alternatively, an attempt to replace the nuclear unit with an extended family generally means that the family will be slower and more inflexible in dealing with tasks which legitimately should go to the nuclear unit.

Science and technology have an equal probability of taking a family function and developing machinery to make it easier to perform that function in a formal organization. In the same way, technology has the possibility of taking tasks which are performed by factories or trained experts and reducing their costs and complexity of operations so that the ordinary family can afford to own them and operate them (Litwak and Figueria 1968). Therefore, the ordinary nuclear family member has in the course of its life to change roles continuously. Spouses may best operate under a concept of role substitutability; husbands and wives must be prepared to change their roles and even substitute one for the other depending on what task is brought into the family and what is taken out.

A concept of role substitutability is of enormous benefit to older people when one spouse dies or is very ill. The other spouse is often forced to undertake the duties of the ill spouse. It may be difficult for the staff to teach respondents the need for role substitutability; however, there may be people who, with slight learning or stimulus, adopt such a role posture easily. Therefore, the staff should be aware of the concept and the need to develop training in this area. The concept of role substitutability may be especially important for older people in a nursing home who do not have spouses. The likelihood of their being remarried may be remote. However, if they have a concept of role substitutability, two people of the same sex can develop a special "buddy relationship" which permits them to handle many of the tasks of the

nuclear family dyad. This has not been thoroughly explored, but it is something the staff of the organization may want to keep in mind as a substitute for the nuclear families where one does not exist.

Clearly there are two different things being discussed with regard to the residents. They may want to form larger residence units which approximate the role of the neighbors in dealing with problems based on geographical proximity and time emergencies. Within this general context, the residents could systematically develop something like a special friend relation where residents seek a functional substitute to the nuclear unit that in turn enables them to handle nontechnical tasks requiring only two people more effectively. The relationship between these friends and the larger residence groups must be kept congenial through recognition that they are semiautonomous. That is, the dyadic friend structure requires the larger resident group to handle nontechnical problems that demand greater resources; otherwise, it does better by itself. Competition between the dyadic and the larger system will be reduced if both members of the dyad participate in the residents' larger unit so that individuals do not feel that participation in one group is competitive with participation with another (Litwak and Szelenyi 1969).

Finally, friendship deals with problems which tend to be related to common generational and occupational experiences. Such sources of nontechnological tasks tend to be unrelated to kinship structures because often kinship involves different generational family members from different occupational spheres. What characterizes the aged is their being of the same generation and as such sharing common experiences—often they have common tastes in movies, drama, appropriate sexual norms, need to fill in the time vacuum created by retirement, problems of being exploited by shopkeepers, needs to have local traffic regulations altered to give them time to cross streets. Ordinarily nontechnical tasks around such peer group areas are the unique functions of friendship groups. However, what characterizes friendship groups among the aged is their fragility and, as a consequence, the lack of long-term commitment. Thus friendship among the aged may take a different course than that of younger people. Like the neighborhood, it must stress mechanisms for integration.

These ideas on primary groups, other than kin, are meant to sensitize the staff to the fact that primary groups can differ in structure and function. They are not meant to provide even a reasonably complete analysis. Rather, they alert the staff to not necessarily treating all primary groups as they do the kin.

References for Part II

Blau, Peter. The Dynamics of Bureaucracy. Chicago: The University of Chicago Press, 1955.

Coleman, James S., et al. *Equality of Educational Opportunity*. Office of Education. Washington, D.C.: Superintendent of Documents, U.S. Government Printing Office, 1966.

Cooper, Eunice, and Jahoda, Marie. The evasion of propaganda. In: *Publication Opinion and Propaganda*. Katz, Daniel; Cartwright, Dorwin; Eldersveld, Samuel; and Lee, Alfred M., eds. New York: Dryden Press, 1954.

Dobrof, Rose. The Care of the Aged: A Shared Function. Paper presented at the American Sociological Association Annual Meeting, Montreal, 1974. (Mimeographed)

Fellin, Phillip, and Litwak, Eugene. Neighborhood cohesion under conditions of mobility. *American Sociological Review*. 28:364-376, 1963.

Festinger, Leon. Architecture and group membership. *Journal of Social Issues*, No. 7, pp. 152-163, 1951.

Festinger, Leon; Schachter, Stanley; and Back, Kurt. *Social Pressures in Informal Groups*. Stanford, California: Stanford University Press, 1963.

Gans, Herbert. *The Urban Villagers*. New York: The Free Press, 1962.

Goldberg, Gertrude. Nonprofessional helpers: The visiting homemakers. In: *Community Action Against Proverty*. George A. Brager and Francis P. Purcell, eds. New Haven, Conn.: College & University Press, 1967.

Goode, Wm. J. *World Revolution and Family Patterns*. Glencoe, Ill.: The Free Press, 1963.

Cottesman, Leonard E. "Nursing Home Performance as Related to Resident Traits, Ownership, Size, and Source of Payment." Paper presented at the 100th Annual Meeting of the American Public Health Association, Atlantic City, New Jersey, November 15, 1972.

Hamburg, David A. Therapeutic aspects of communication and administrative policy in the psychiatric section of a general hospital. In: *The Patient and the Mental Hospital*. Greenblatt, Milton, et al., eds. Glencoe, Ill.: The Free Press, 1957.

Hovland, Carl I. Effects of the mass media of communication. In: *Handbook of Social Psychology*, Vol. II. Lindzey, Gardner, ed. Cambridge, Mass.: Addeson-Wesley, pp. 1062-1103, 1954.

Hyman, Herbert H., and Sheatsley, Paul. B. Some reasons why information campaigns fail. *Public Opinion Quarterly*, XI, pp. 412-23, Fall 1947.

Litwak, Eugene. Geographic mobility and extended family cohesion. *American Sociological Review*, XXV: 385-94, June 1960a.

Litwak, Eugene. Occupational mobility and extended family cohesion. *American Sociological Review*, XXV: 9-21, February 1960b.

Litwak, Eugene. Extended kin relations in an industrial democratic society. In: Shanas, E., and Streib, G., eds. *Social Structures and the Family Generational Relations*. Englewood Cliffs, N.J.: Prentice-Hall, 1965. pp. 290-326.

Litwak, Eugene and Figueira, J. Technological innovation and theoretical functions of primary groups and bureaucratic structures. *American Journal of Sociology* 73: 468-81, January 1968.

Litwak, Eugene, and Szelenyi, Ivan. Primary group structures and their functions: Kin, neighbors, and friends. *American Sociological Review* XXXIV: 465-481, August 1969.

Litwak, Eugene; Shiroi, Earl; Zimmerman, Libby; and Bernstein, Jessie. Community participation in bureaucratic organization: Principles and strategy. *Interchange*, 1.(4): 44-59, 1970.

Litwak, Eugene, and Meyer, Henry J. Administrative styles and community linkages of public schools: Some theoretical considerations. In: Reiss, Albert, ed. *Schools in a Changing Society*, New York: The Free Press, 1965. pp. 49-98.

Litwak, Eugene, and Meyer, Henry J. A balance theory of coordination between bureaucratic organizations and community primary groups. *Administrative Science Quarterly* II: 31-58, June 1966.

Litwak, Eugene, and Meyer, Henry J. *School, Family, and Neighborhood: The Theory and Practice of School-Community Relations*. New York: Columbia University Press, 1974.

Litwak, Eugene; Meyer, Henry; and Hollister, David. Theories of Linkage Between Bureaucracies and Community Primary Groups-Education, Health, and Political Action as Empirical Cases in Point, Paper presented at the American Sociological Association Annual Meeting, Montreal, 1974.

Parsons, Talcott. The social structure of the family. In: Anshen, Ruth N., ed. *The Family: Its Function and Destiny*. New York: Harper, 1959 (revised).

Parsons, Talcott. The stability of the American family system. In: Bell, Normal W., and Vogel, Ezra F., eds. *A Modern Introduction to the Family*. New York: The Free Press, 1968.

Perrow, Charles. A Framework for the comparative analysis of organizations. *American Sociological Review* 32: April 1967.

Rosow, Irving. *The Social Integration of the Aged*. New York: The Free Press, 1967.

Shils, Edward. Primary groups in the American Army. In: *Studies in the Scope and Methods of the "Ameri-*

can Soldier". Merton, Robert K., and Lazarsfeld, Paul F., eds. Glencoe, Ill.: Free Press, 1951.

Shils, Edward, and Janowitz, Morris. Cohesion and disintegration in the Wehrmacht in World War II. In: Katz, Daniel; Cartwright, Dorwin; Eldersveld, Samuel; and Lee, Alfred M., eds. *Public Opinion and Propaganda.* New York: Dryden Press, 1954.

Thompson, J.D. *Organizations in Action.* New York: McGraw-Hill, 1967.

Warner, W. Lloyd, and Lunt, Paul S. *The Social Life of a Modern Community.* New Haven: Yale University Press, 1941.

Weber, Max. *The Theory of Social Economic Organization* (A.M. Henderson and Talcott Parsons, translators). New York: Oxford Press, 1947.

Whyte, W.F. *Street Corner Society.* Chicago: University of Chicago Press, 1955.

Whyte, W.H. *The Organization Man.* New York: Simon and Schuster, 1961.

Other Sources

I am grateful to Marguerite Holmes, R.N., Ed.D., Dean Emeritus, Hunter-Bellevue School of Nursing of the City University of New York. She reviewed content about nursing care and norms governing treatment by physicians of members of their own families.

U.S. GOVERNMENT PRINTING OFFICE : 1977 O—243-962